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USE OF ESTROGENS AND PROGESTERONE*

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THE HORMONES which have essential uses (especially appropriate) in the female include the estrogens and the progestogens. Of the first there are several, which need to be identified. The most potent per milligram is estradiol, which may be administered in this form, or for more prolonged action in the form of a benzoate or propionate ester, which is slowly hydrolyzed after injection. Because of cost estradiol is often replaced by one of the estrogens which occurs as a urinary excretion product, either estrone or the less potent estriol. A widely used preparation which is called by the Council on Pharmacy and Chemistry "Estrogenic Substances" contains all three of these substances but estrone is predominant. This may be prepared in various stages of purity. Being a mixture, it cannot be standardized in weight terms, but is measured in biological units, compared with international standard estrone. One unique estrogen is ethinyl estradiol, a synthetic derivative of estradiol which is efficiently absorbed when given orally.

The completely synthetic estrogens include the best known diethylstilbestrol, often called stilbestrol, and modified forms such as methyl ethyl stilbestrol and hexestrol which have slightly different characteristics of absorption and activity. Two other synthetics are benzestrol of somewhat lower potency, and the more recently tried dienesestrol with very high potency. The general advantage

of these synthetic drugs is their small loss when they are given orally instead of parenterally. The disadvantage is the tendency to cause nausea in a significant proportion of women who use them. In spite of the lower cost of the synthetics generally, they are certainly not replacing the natural estrogens.

The types of preparation available are almost as varied as the number of estrogens. The low solubility of estrogens and their esters in water, and the fact that an oil solution placed intramuscularly serves as a reservoir for continued absorption over a period of several days, while the estrogens dissolve out of the oil into the aqueous tissue fluids, has resulted in a great vogue of injection oil solutions. The disadvantages of these injections are that the oils tend to remain where they have been injected, that frequently foreign body reactions occur about such masses of oil, that there are occasional allergic reactions to the oil solvents, and that the absorption from such a depot is not uniform throughout the week or ten days usually allowed to occur between injections.

A more recently introduced technique for obtaining sustained activity of the individual doses is the placing of pellets of pure hormones in loose subcutaneous tissue spaces. Disadvantages include difficulty in establishing the appropriate dose, foreign body reactions, and difficulties in assuring and maintaining sterility of the solid pellets during the technical procedures of introducing the doses. It seems probable that this method will be interesting but not a serious competitor for wide use.

Within the past few years a number of experiments have shown that it is possible to administer the estrogens as a suspension of microscopic crystals in water, sometimes stabilized by addition of substances which delay settling of the small crys-

continued on next page

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tals. This method seems to achieve the advantages of the oil solutions without the handicaps mentioned. Wider future development is predicted.

Any of the estrogens may be administered orally with typical effect. There is a large loss of potency which has been explained on the basis of chemical changes of some of the estrogens by the liver and excretion of these compounds in the bile. Certain of the metabolic products retain a portion of their estrogenic activity, as for example estrone made from estradiol. One may have to use as much as five times the dose orally that he would give parenterally. If the oral preparations can be made less costly by using less highly purified materials and omitting sterilization for ampul preparation, the cost of the larger amount of hormone may not be a significant handicap. Oral therapy is widely used. Its disadvantage, aside from the dose, is that self-medication is more apt to occur with oral preparations. On the other hand the use of one or more doses daily tends to provide a more uniform level of estrogenic activity than does injection at intervals of a week.

Estrogens can be administered percutaneously, either as alcoholic solutions or in cosmetic creams. This latter route is at present largely out of professional control, with dosage indeterminate. Estrogens so administered may give general or systemic results, but this route is in use chiefly by women who are seeking to avoid or remove the senile changes about the face. One recent paper gives objective evidence that some benefits can be secured. Medical supervision of this type of therapy is a matter of real importance. There is a further possibility for local application in the relieving of senile changes about the pudendal area in many women who suffer from pruritis or advancing changes in the vulva and vagina.

Estrogens were administered by vaginal pessaries or suppositories in the early days of estrogenic therapy for the menopause syndrome. This route is inefficient in terms of the dose absorbed, and undesirable from an esthetic point of view. But it is still helpful when there is any reason to secure the rapid maturing of an adult type of vaginal mucosa in a pre-adolescent girl. This was formerly much used in treating pre-adolescent gonorrhea but has become less important with the introduction of effective antibiotics.

The progestogenic hormone picture is far less complicated. One hormone occurs naturally, progesterone. The known metabolic end-product, pregnandiol, is not biologically active. This occurs in the urine, representing less than half the progesterone produced or administered. Since oral administration of progesterone is ineffective, there has been developed a modified form which is made synthetically, called pregneninolone. The dose of this preparation by mouth must be some ten or

more times that of the parenterally administered progesterone to obtain a similar effect. Progesterone is administered in oil solution only. In contact with water it is subject to gradual oxidation.

Anterior Pituitary and Ovary Relationship

For an understanding of the physiology of ovarian action, the interactions of the anterior pituitary and ovaries must be included. The term "gonadotrophic hormone" is applied to substances which stimulate the gonads, either ovary or testis. At present there are thought to be at least three such hormones produced by the anterior pituitary. These cause the Graafian follicles to grow and develop, usually one at a time. At the peak of follicle development, the matured ovum is extruded from the ruptured follicle. Following this ovulation the pituitary hormones bring about a change in the follicle cells which has led to the name "corpus luteum." After a period of about one week of activity, the corpus luteum begins to atrophy, eventually disappearing. Neither follicle development, maturation of ovum, ovulation, nor formation and function of the corpus luteum can occur without the gonadotrophic hormones.

A still more puzzling situation is produced by the fact that the follicle produces estrogenic hormone and the corpus luteum secretes progesterone. These hormones have their best known effects upon the uterus, Fallopian tubes, vaginal mucosa, and breasts. But estrogenic hormones and progesterone exert a series of effects upon the anterior pituitary gland. Although the details of this reflex action are still imperfectly understood, it is certain that the dependably regular recurrence of cycles of ovarian functions as described are brought about by the combined effects of pituitary upon ovaries and of ovarian hormones upon the anterior pituitary. Possible uses of the ovarian hormones in attempts to alter pituitary function will be mentioned later.

Indications for Use of These Hormones

The most obvious use of estrogenic material is for replacement in the menopause syndrome. The only need is to give relief from the numerous symptoms, but when these do not occur or are very mild, therapy is not required. The use of estrogens should be started with a large enough dose to assure significant relief within the first week. The doses may be adjusted upward by rapid stages to secure complete comfort in a few days in most cases. When this point has been reached it is wise to reduce more slowly the amount of estrogen employed until recurrence of some of the typical complaints indicates the need for return to a higher level. Once this satisfactory minimum dose has been reached, there is only one way to find when it is no longer required: reduce the dose again until symptoms recur. Eventually it always becomes possible to eliminate estrogen entirely without re-

turn of the menopause syndrome. The duration of treatment may be from a few weeks to several years. Certainly there is excellent reason to assure women that such a program of therapy does not prolong the readjustment, nor make it necessary to undergo such a period after withdrawal of the treatment. The readjustment is made essentially asymptomatic by therapy if the program is skillfully handled.

There are frequently women who have the typical complaints suggesting the climacteric syndrome, but who continue to have menstrual function, often for many years. Although sometimes this may be referable to disturbances in the central and vegetative nervous systems, it is common to find other evidences of hypofunction of the ovaries. There may be menstrual irregularities, low fertility, or poor feminine development to indicate possible estrogen deficiency. Estrogenic therapy may be as helpful as in the truly menopausal women, but the syndrome is commonly of variable intensity, and use of a fixed dose level of administered estrogen gives variable comfort to the patients. Such women need a greater amount of clinical experimentation with doses to secure the best results. It is rather probable that such conditions can be managed with greater ease if combined use of estrogen and progesterone are tried. If one can estimate the timing of the menstrual cycles well enough in advance, he would add to the routine estrogen a significant dose of progesterone through the third week, and either reduce the estrogen sharply or withdraw it entirely during the fourth week, resuming estrogen again as soon as the flow is well under way.

When adolescent development is significantly delayed or when a woman of mature years desires treatment because of inadequately developed breasts or internal genitalia, the problem is essentially similar to that presented by infrequent menstruation or by amenorrhea which is not caused by pregnancy, the menopause, or obvious systemic diseases. The choice needs to be made between stimulation of the ovaries by means of gonadotrophic hormones from the pituitary or pregnant mare's serum, or substitution with the products of the ovaries, estrogen and progesterone. These latter may be expected to give more prompt responses, as well as to operate in certain cases where the ovaries are refractory for unknown causes. Until this refractory state has been found by trial it seems preferable to employ the gonadotrophic hormones, since at times these have led to ovulation and fertility. Substitution with ovarian hormones will not stimulate the ovaries, unless by some possible reflex action, via the pituitary, ovarian function may be improved. This latter possibility is too uncertain for any other than frankly experimental therapy. If substitution therapy with ovarian materials is

to be undertaken, it is urged that regular cycles of estrogen for at least three weeks be accompanied during the third week by progesterone. The fourth week may be marked by complete withdrawal of hormone treatment, or by continued use of a minimum dose of estrogen if there are symptoms which seem to be kept in abeyance thereby.

In order to induce ovulation a number of procedures have been tried but none can be considered dependable. Intravenous use of gonadotrophic hormones has been reported but with the present impure hormones this is not advisable. Cycles of use of such hormones hypodermically during the first two weeks of the cycle, when that timing can be recognized, have led to ovulation proven in a few instances by pregnancies. There is some reason to think that the normal mechanism which initiates ovulation is a sharp rise in the amount of estrogen released from the ovaries. This affects the anterior pituitary, leading to sudden release of the trophic hormones which in turn affect the mature graafian follicle, and cause ovulation, which is followed by formation of a corpus luteum. Therefore attempts have been made to induce ovulation in women who have frequent anovulatory cycles by giving a large single dose of estrogen at about the fourteenth day of a cycle. This is without known risk. The efficacy can be told by improvement in fertility, or by comparative endometrial biopsies at the end of the third week with and without therapy, or by determinations of the pregnandiol excretion over the several days following the therapy as compared with a similar time in an untreated cycle. These criteria indicate the difficulties in proving the efficiency of this method of therapy and shows why reports on large series are lacking.

Several uses of estrogen have become associated empirically with dermatologic practice. There is a chronic cystic type of acne seen in mature women as well as occasionally in adolescent girls, which appears to respond better to local application if these patients receive small doses of estrogen over long periods of time. If the doses of estrogen are too large the menstrual cycles may be made irregular. Small doses do not disturb the cycles. It is extremely difficult to secure more than clinical impressions on this matter of results in acne, but experience on this point is widespread.

There are changes in the skin associated with the climacteric which include a thinning of the epidermis, decrease in the subcutaneous connective tissues, and decreased vascularity. These changes may be of only cosmetic import on the face and neck but may also be the cause of great discomfort and susceptibility to trauma and infection about the genitalia. Application of estrogen locally has been known to help the pudendal lesions, which respond also to large doses given systemically for the treat-

continued on next page

ment of climateric symptoms. In the past few years the use of estrogens in cosmetic preparations has become common but only recently has there appeared any exact study of the skin and adjacent tissues to afford objective data that such therapy accomplishes more than similar creams without the hormones. It now appears that the use of the hormone on the skin is followed not only by absorption, as has been known for a number of years, but that the effects are marked locally with improvement in the thickness of a senile thin skin, and improvement in the atrophied connective tissues beneath the epidermis. The quantitative aspects, doses required, permanence of results, and many other details remain to be determined.

One very natural question which is raised by this technique is the possibility of inducing malignant disease by use of estrogens daily on the skin. The fear of initiating malignant growths by any clinical use of estrogens is obviously decreasing in the last few years. Those men who are engaged in experimental study of cancer tend to the opinion that estrogens do not furnish the stimulus which initiates malignant growth, but that given such an initiating factor, whatever it may be, estrogenic hormones are growth stimulants for genital tissues, breasts, and possibly the skin. Whether every possible source of estrogen should be eradicated from women with certain types of cancer remains under debate. If the decision is made to remove the ovaries for this reason, then there is equally good reason to withhold all estrogens including cosmetics from the same patients. It is too early to contemplate the hormone-containing cosmetics with entire complacency.

The use of progesterone has far fewer indications than is the case with estrogens. In addition to the situations described above, which might be generally described as inadequate ovarian cycles, the two other major indications for use of the corpus luteum hormone are in repeated abortion and certain toxemias of pregnancy. The latter have been under study by Priscilla White and the Smiths, with much attention to pregnant diabetic women. Here there has been a remarkable improvement in maternal morbidity and infant survival following the use of large doses of estrogen and what seem like impossibly great doses of progesterone. Such treatment needs to be continued well past the beginning of the second trimester. The final details are still to be determined. The most recent papers of these authors need to be consulted for directions. The large doses of progesterone advised will soon be available for more patients since commercial preparations of progesterone are now being reduced in cost, together with introduction of higher concentrations of the hormone in the oil vehicles for injection. It seems probable that better results will be secured if more generous doses of

progesterone are employed in treating women who have suffered abortion repeatedly in the first trimester. This should be started as soon as the probable ovulation has occurred, even before the first missed menstrual period, and be continued to the early part of the second trimester, possibly longer. Such advice poses a difficult question: adequately large doses of progesterone continued from the time of ovulation will postpone menstruation for long periods and might therefore lead to a period of treating a woman as though she were pregnant whereas she has not conceived. The risk of such expensive therapy being ultimately futile is to be balanced against the urgency of stabilizing the much desired pregnancy.

One other use for progesterone which is not widely explored is in the treatment of women whose breasts become painful, tender, and marked by a temporary engorgement of glandular structures. The etiology of this condition is by no means entirely understood, but the condition seems at times to result from persistent use of large doses of estrogen or to be aggravated by such therapy. Use of brief periods of progesterone treatment, such as three to seven days, may lead to prompt relief from the discomfort, and loss of the turgidity in the breasts judged by palpation. Such cycles of treatment may be repeated when indicated. In some women relief is obtained with a total dosage of a few milligrams.

The Cause of Menstruation

The mechanism which leads to menstrual flow continues an object of much study. The usual explanation has been that of estrogen withdrawal or progesterone withdrawal. It is known that flows usually follow either of the following two procedures: (1) if the endometrium is caused to develop by an adequate supply of estrogen, which is then greatly reduced or entirely withdrawn; (2) if estrogenic stimulation is followed by an adequate supply of progesterone, which is in turn greatly reduced or withdrawn. In the latter case flow follows even though the estrogen level is unaltered.

Certain difficulties with the explanation just outlined have compelled several investigators to search for still further factors. Recent suggestions made are as follows. A globulin derived from certain alterations in the endometrium (G. V. Smith and O. W. Smith) acts as a vasoconstricting agent upon the sphincteric muscles in the walls of the smallest arterioles in the endometrium. The result includes a shift of circulation from capillaries to the arterio-venous anastomoses or venous lakes in the endometrium. This induces a relative anoxia of the tissues, which leads in turn to foci of necrosis, and shedding of the necrotic tissue with some blood loss follows. (Okkels; Markee).

continued on page 516

LOBOTOMY*

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PREFRONTAL LOBOTOMY or leucotomy is a neuro-surgical procedure which has proven itself to be of benefit to a proportion of individuals among those selected for this form of treatment in certain types of neuropsychiatric disorder or disease of the personality. One of the chief aims of psychotherapy, whatever its method, is to change people. This goal is not readily attainable because the human personality is rooted in a genetic pattern that parallels the fixed character of somatic individuality. The individual personality is conditioned and modified by environmental experience that furnishes the data through which the psychiatrist interprets the patient's difficulty and decides what means he will use to effect possible change. He may choose to work indirectly through the environmental experience of the subject; he may choose drugs or talk, or some kind of shock treatment. Alteration in the subject's reaction to his disease, which brings about sustained improvement in his behavior and social adjustment, is the ultimate goal. Lobotomy appears to cause a more permanent change in the deranged personality than any other form of treatment. Whether or not the outcome is for the better depends mainly upon the selective judgment of the neuropsychiatrist.

Elective incision of the prefrontal portion of the brain is the application to psychiatry of a surgical method derived from observations extending over 50 years in several related fields: The results of injuries to the frontal lobes and resection for tumor, cyst, or abscess; the study of animal behavior following extirpation experiments on the brain affecting the prefrontal areas; from neuro-anatomical research on the cortex and its connections, and especially the phylogenetic and developmental relationships which have been correlated with psychological function.

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"Change of personality" is a familiar notation on the records of frontal lobe syndromes and represents the external manifestation of change, both qualitative and quantitative, in vegetative, emotional, and inhibitory impulses on the projection system of the frontal cortex. The interneuronal connections of the frontal lobe, being of greater number and extent than any other of the conventional cortical divisions, reflects disease more often in the personality than in neurologic signs of precise localization. Symptoms related to areas anterior to motor and premotor are not displayed in mode of specific function but with reference to total behavior: Attention, recall, emotion, perception, posture—these are general attitudes, but they mirror the individual. They are not easily interpreted and catalogued in the handbook of differential diagnosis.

Personality change in tumor or degenerative process of the frontal lobe may be so insidious as to escape detection until far advances. Traumatic lesions furnish more dramatic clinical evidence of the physiological role of the prefrontal areas. The case of Phineas Gage, who had an iron bar blown upward through his anterior fossa in 1848, is impressed upon medical students as an encouraging example of how they can probably get along all right minus most of their brains. You will recall how Phineas Gage, following his injury, changed from a taciturn and methodical construction foreman to a character described as "fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference to his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate yet capricious and vacillating, devising many plans for future operations which are no sooner arranged than they are abandoned in turn for others appearing more feasible." Or take a case from my own war experience: A modest, serious-minded Marine corporal, who recovered from a gunshot wound through the temples, complicated by meningitis, to become a cheerful extrovert who discusses his blindness with carefree levity. There are many similar instances of personality change in individuals who have been accidentally lobotomized or surgically lobectomized

continued on next page

for a frontal lesion. They have taught us much about the potentialities of the forebrain; and principally that it must be treated with great respect.

Dr. John Fulton, Professor of Physiology at Yale, probably could be called the modern stepfather of psychosurgery; and he would undoubtedly regard his many children as illegitimate at the present time. It was his outstanding experimental work (with Dr. Jacobsen and others) on frontal lobe physiology in primates that gave first impetus to lobotomy. Their presentation at the London International Neurological Congress in 1935 included observations of improved temperament and tractability in chimpanzees subjected to cortical excision primarily for the purpose of studying motor behavior. Egas Moniz, the Portuguese neurologist, was thereby prompted to try prefrontal incision on human psychotics. He had long considered the possibility of operating on the brain for the relief of mental symptoms, a feat which Burckhardt had attempted 50 years previously, also on the basis of earlier animal experimentation by Goltz. Moniz in Europe, who was, by the way, almost killed in 1939 by the homicidal attack of a deluded patient, and Freeman and Watts in America deserve pioneer credit for the rational development of lobotomy during the past decade and for its increasing acceptance by psychiatry. Major guidance, however, has been provided by neurophysiology. Fulton and Jacobsen in 1934, commenting about a chimpanzee that before operation threw temper tantrums when mistakes were made (having to do with food reward) in delayed reaction or other tests of recent memory performance, stated that removal of frontal cortical areas appeared to reduce the capacity for recall and to increase the importance of immediate sensory cues as determinants of response, possibly thereby preventing the occurrence of experimental neurosis in more complex and abstract situations. The chimp had been trained to utilize a variety of sensory stimuli to solve mechanical problems that would tax many a human brain. Following a specific type of operation on the forebrain and a considerable vacation away from experimental apparatus, the same animal, nevertheless, was able to reproduce its complicated preoperative performance fairly well under similar conditions. Explosive frustration reactions, precipitated before operation by errors precluding food reward, no longer occurred. The inference here clearly parallels the emotional improvement witnessed in the human case of agitated psychosis after lobotomy.

There is evidence to indicate that the mesial-orbital cortex of the frontal lobe (which I shall show you later) plays an important role in the motivation of emotional activity. When fiber tract connections in this region are cut in the ape, the

animal exhibits the type of behavior just described; but ablation of this area may produce a condition stimulating sham-rage, or a disturbed state of hypermotility—the so-called pacing reaction in which the animal spends most of its time pacing back and forth in its cage. Experimentation of this type in neurophysiology and psychology will continue to provide invaluable direction to those who recommend and carry out lobotomy in man, not the least of which will be to stay the hand of the enthusiast.

Prefrontal lobotomy has been called (by one of my urological friends) the egg-beater operation and not perhaps without some slight justification. The technique is no more imperfect than our knowledge of frontal lobe function. The procedure is not simply a matter of sticking an instrument in somewhere up forward and stirring it around. We have incomplete but fair information about the neuroanatomical pathways and the related nuclear centers that are affected by lobotomy.

A variable proportion of long and short association bundles, depending on the extent of the incision through the white matter, are divided in the coronal-sphenoidal plane thus diminishing in variable degree the interconnections between area 13 and adjacent areas, the function of which is also poorly understood—thus diminishing their intercommunication literally with the rest of the brain.

The human cerebral cortex, representing the most highly differentiated part of the brain in its evolution, is really 3 lobes instead of 5—right and left. Five lobes have been handed down by anatomical tradition as a convenient way to divide up the gross surface of the organ; but functionally and in kinship to lower forms there are only 3 on each side which have been designated the outer—ectocortex, middle—mesocortex, and inner—entocortex.

These three lobes maintain a constant relationship with one another and the rest of the nervous system throughout vertebrate morphology. In man the frontal portion of the outer or ectocortex, in contradistinction to the remainder of the entire cerebral mantle, is unique in having by far the greatest number of interconnections with other functional units of the nervous system, irrespective of anatomical arrangement.

Prefrontal 13, 14 and possibly adjacent areas 9, 10 and 11 are greatly influenced by autonomic impulses having to do with vegetative and instinctive motivation, mediated by circuits to the hypothalamus, some directly but mostly indirectly through the thalamus. It is by severing part of the myriad of connections between these most recently developed areas and those of older and less modifiable function (thalamus, hypothalamus, and other cortical areas) that lobotomy theoretically aims to improve the sick personality.

The thalamus and the geniculate bodies, which are an integral part of it, is the principal synaptic surface of sensation. Through its portals pass everything from the most beautiful girls in the world to a glimpse of eternity. External and internal stimuli of all kinds are registered here as on a radar screen where they are processed and redistributed for shaping conscious activity or for storage in the unconscious. The thalamus and cortex act like an electrical feed-back system; but the ratio of output from thalamus to what is returned from cortex is about 8:1—a preponderance that overshadows linkage with basal ganglia, mid-brain tegmental nuclei and other centers. Lobotomy, therefore, divides many more thalamo-frontal fibers than fibers flowing in the opposite direction.

We can name bundles of fibers that are divided or partially divided by the operation, but they represent unfamiliar gross structures that have little physiological meaning:

- 1—superior longitudinal fasciculus—short relay association tract
- 2—cingulate bundle—short relay association tract
- 3—uncinate and medial orbital bundles—long relay association tracts
- 4—possibly some fibers of inferior longitudinal fasciculus and maybe others—? subcallosal
- 5—these long and short relay association tracts link up the three basic divisions of the cortex previously mentioned—outer ectocortex, middle mesocortex (cingulum), and inner entocortex (olfactory)
- 6—interconnecting direct relays between thalamus, hypothalamus, and prefrontal cortex, many of which are hypothetical

Degeneration, chiefly thalamofugal and in the dorsomedial nucleus of the thalamus, has been recorded from post-lobotomy cases of several years' standing who have come to autopsy.

Hypothalamus is also included in this complex hookup, but less is known about this vital structure than is known about the atomic bomb. Perhaps we can borrow from the physicists and say that the purpose of lobotomy from the neurophysiological standpoint is to diminish the impact or exchange of energy in the trinitarian system of sensory perception and projection—thalamus, hypothalamus, and prefrontal cortex (Many other cortical areas are included secondarily in this complicated mechanism—paracentral and parietal sensory cortex, occipital visual, auditory, etc.)

Now, what does all this mean in common sense medical language? It means that at least 10 per cent, by conservative guess, of persons suffering from mental disorders of many kinds, both in and

out of institutional confinement, may be helped by lobotomy. The procedure has been carried out on approximately 0.3 per cent of an estimated 650,000 insane population in the U. S. from official figures with variable improvement in approximately half the cases.

There is scarcely an age limit. If the patient is sound enough to withstand any type of major operation, he will survive lobotomy. A large portion of those who have been lobotomized have come from state asylums where diet and physical hygiene are below the average civilian standard. The chief immediate hazards are hemorrhage and infection, which are not peculiar to neurosurgery alone. The mortality should not exceed 1-2 per cent.

Successful lobotomy depends primarily upon successful cooperation between the neuropsychiatrist and the neurosurgeon. One recommends and the other operates. The former also follows the case for a long period afterward, but the neurosurgeon also looks over his colleague's shoulder occasionally. Although it is presuming for me to discuss indications and results from the psychiatric standpoint, I shall try to do so briefly because many of you are probably more interested in this aspect than in what has gone before.

Lobotomy has been done on nearly every type of psychotic disorder. As in shock therapy, selection is based on symptoms rather than on classification of mental disease. I have lobotomized a 13-year-old imbecilic boy because of continuous assaultive and destructive behavior and a 76-year-old female with chronic involutional complaints. The symptomatic improvement was excellent in both. Most encouraging follow-ups are obtained in the affective reaction syndromes: Involutional melancholia and chronic recurrent depressions of variable cause and content. Less encouraging are cases that might be called the psychoneurotic-compulsive-obsessive group, and least improved are the schizophrenics, although brilliant results can be cited among the latter. Schizophrenia, comprising the most heterogenous and malignant aggregate of all, naturally presents the greatest difficulties of selection. The operation has also been used to ameliorate the terrible reaction caused by intractable pain in patients not amenable to anatomical block by incision of the conduction pathways. Prolonged pain gives rise to a type of symptomatic psychosis; lobotomy somehow appears to dampen the overwhelming bombardment of pain on consciousness.

My experience is not unlike that of others who have drawn their material largely from the inmates of state institutions. Patients assigned to me at Boston State Hospital generally were the most aggressive, noisy and assaultive—who required the greatest amount of nursing supervision from a

continued on page 519

OCCUPATIONAL MEDICINE AND ITS RELATIONSHIP TO PRESENT DAY INDUSTRIAL RELATIONS*

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AMERICA has learned one big lesson from the war: that when employe and employer really and truly cooperate in the interests of all-out production, the output of their factories and business cannot only be doubled but in some cases trebled. This is not theory, it is the actual war production record of the greatest industrial country in the world. The record will stand for all time, as proof of what free labor and free management working together can achieve. The good employe-employer relationships which existed during the war was somewhat enhanced by a sense of duty and patriotism on the part of management and labor. In addition there were war-time government restrictions placed on both. In the wake of the war these reasons no longer exist.

The war has conclusively proved the costliness and foolishness of industrial strife, bickering and misunderstanding. The successful business today must concern itself seriously with building sound relationships with their employes and failure to promote better human relations will result in the failure of our system of free enterprise and free labor. The situation is a challenge to the leaders of both management and labor who are jointly responsible for industrial relations. Upon them must fall the task of "selling" the importance of cooperation to both labor and management. Upon them depends, more than upon any other group, the creation of an employe-employer environment which will be a firm foundation for an enlightened labor-management relationship.

An attempt will be made in this paper to show that our present day concept of occupational medicine will help to create and maintain health, security, happiness and good morale in industry. In order to do this it will be necessary to review briefly the history and course which medicine has taken in industry.

* Presented at the Annual Conference, New England Industrial Physicians, at Providence, May 7, 1947.

There are many who believe that the changes and progress made in industrial medical practice during the past twenty years have been largely due to the efforts of those engaged in industrial medical work. This is a common misconception; the facts are that industry itself is largely responsible. However, some credit must be given to a certain minority group of physicians who have contributed much to the progress made in this specialized field of medicine. In order to prove this, one need only to consider some of the fundamental reasons why industry ever became interested in this profession. Although industrial medicine has been recognized for centuries it was not until the State Compensation Laws imposed financial hardships on industries that doctors became a necessity. Industry very soon realized that their operation costs and profits were seriously influenced by loss of manpower resulting from injuries. From a Compensation standpoint, two things had to be done to remain in business. First, to provide adequate treatment to the injured; secondly, (and much more important than the first from a cost standpoint), the reduction and possible prevention of all accidents. This program required assistance from two professions, namely, doctors and engineers. The emphasis, as I will attempt to show you, was always placed on prevention.

The physicians engaged by the industries to treat the injured were usually surgeons. In many instances, however, physicians were engaged with little or no special training in surgery. Most always this physician, if he remained in industry, would sooner or later become a surgeon, whether or not he sought out surgery as a specialty. Many of our middle-aged and older surgeons today have attained their surgical experience and prominence via this route. I am informed that this type of surgical residency is now virtually non-existent. There are perhaps two reasons for this; first, because of the policies set up by the surgical boards; secondly, because of the effectiveness of industry's preventive surgical program. In the average industrial city today with a total population of 100,000, there isn't enough major industrial surgery to keep one man busy.

Proud of their efforts in preventive surgery, industry began to explore more deeply the field of preventive medicine. It was reasonable to presume that a worker with all of his facilities and in good health would not get hurt or lose time from work as readily as those who had physical or mental disabilities. These conclusions lead many industries to inaugurate a pre-employment physical examination program which was essentially a screening process. Applicants who had physical or mental defects were not accepted for employment. Labor, in general, reacted unfavorably to this plan. The war altered this policy. Many of the physically and mentally handicapped who were previously rejected for employment were now satisfactorily placed in industry. Consequently the pre-employment or screening physical examination is now called "the pre-placement physical examination".

Most surgeons were too busy to participate in this new phase of industrial medicine. Industry then turned to the medical profession in general for assistance and the surgeon dropped out of the scene. As the program proved itself valuable the examinations were extended to older employees; this plan served at once to establish a satisfactory relationship between the workers and the medical department. Employees with treatable defects were referred to their personal physicians or to proper agencies for supervision. Occasionally during the examination itself it was possible to do some effective health education work. The findings on examination might have revealed the necessity for a job transfer in the interest of health and safety of fellow workers or of a whole department. A timely job transfer might be the means of delaying total disability in the face of a chronic, slowly progressing illness.

Later the program was made to include partial examinations of employees who became ill while at work, and also employees returning to work following an absence due to illness. A full program also included periodic partial examinations of employees known to be working with toxic materials and the accumulated records were made the subject of constant study and review. The information gained was correlated with the knowledge of production men and hygiene and safety engineers concerning the working environments of the employees.

Today many of our industries and businesses are equipped with elaborate hospitals and staffed by full-time nurses, physicians and clerks. The scope of work in organizations with this type of medical service is outlined briefly as follows:

1. Complete pre-employment and periodic physical examinations on all employees, including: chest x-rays, blood counts, serological tests, urine analyses, electrocardiograms and basil metabolism tests.
2. Treatment of all occupational injuries and diseases. Minor conditions are most always cared for by the existing plant medical staff. Major cases are referred to specialists in the various fields: surgeons, oculists, dermatologists, dentists, orthopedists, psychiatrists, urologists, etc.
3. Plant Sanitation and Hygiene:
 - a. water supply
 - b. general housekeeping
 - c. illumination
 - d. air conditioning
 - e. noise control
4. Personal Hygiene for Workers:
 - a. toilets and washrooms
 - b. fatigue control
 - c. nutrition — lunch room
 - d. housing
 - e. recreation
 - f. mental hygiene
5. Co-ordination of Industrial and Community Health Service:
 - a. communicable disease control
 - b. industrial waste control
 - c. vital statistics
 - d. health and safety codes and regulations
6. Industrial Health Exposures:
 - a. abnormalities of air pressure
 - b. abnormalities of temperature and humidity
 - c. dampness
 - d. dusts
 - e. infections
 - f. radiant energy
 - g. poisons
 - h. essential toxicology and safe concentration codes
7. Plant Surveys:
 - a. identification of exposures
 - b. sampling apparatus and analytical methods
 - c. control of exposures and maintenance of controls
8. Job and Worker Analyses:
 - a. aptitude and psychologic tests
 - b. hours of work
 - c. shifts — night work
 - d. women in industry
 - e. environmental factors
 - f. peak loads
9. Statistics:
 - a. incidence, costs and classification of industrial accidents, occupational diseases and non-occupational disabilities

continued on next page

10. Workmen's Compensation :
 - a. administrative methods, regulations and insurance practices
 - b. employment of the physically handicapped
11. Industrial Relations Plans :
 - a. insurance plans
 - b. sickness and accident benefits
 - c. pensions
12. Rehabilitation

Within the past several years, the unions have taken a very active interest in the subject of occupational medicine, health security and welfare. In many instances where adequate medical service was not available in industry they have taken the initiative. It was extremely unfortunate that certain industries and industrial physicians were recently indicted because of this failure to provide adequate occupational hygiene measures for their employees.

Industry through the organization of scientific means for insurance against disease, for its cure and prevention, have an agency within their grasp, perfectly legitimate in its nature, to offset some of the most destructive forms of radicalism, and to protect their workers from the fear that they will be left alone and helpless when they are sick. This is a legitimate motive only insofar as you actually create and provide far better agencies than would otherwise be at hand. Working people are far more subject to charlatanism in medicine, which preys upon superstition and fear, than are other classes. If we can lift the veil of superstition and show the value of scientific prevention and diagnosis, we can leave the cures to take care of themselves. But both prevention and diagnosis are serious and costly studies, and cannot be undertaken lightly or from any purely selfish point of view. The problem, therefore, if it is to be attacked comprehensively, must be by a combined attack, from the humanitarian, the protective and the economic points of view. Each one of these offers a true incentive when it is sincerely used and each suggests its own method of procedure. Taken together, they accumulate a foundation upon which the most effective medical department can be built up and maintained.

The old time industrial physician no longer exists in our most progressive companies today. Employees referred to him many times as "saw-bones" and too often associated him with accidents and a witness against them in compensation cases. Today the employee's health is a major concern of many of our successful companies and the attainment and maintenance of an employee's health is the primary objective of occupational medicine—true Preventive Medicine. In industries where this concept has been put in practice you will invariably find good employee-employer relationships.

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USE OF ESTROGENS AND PROGESTERONE

continued from page 510

tioned that the same globulin, which the Smiths call a "menstrual toxin" is thought by them to be a factor in causing the hypertensive and renal toxemias in pregnancy. It is too early to have any preparations of such globulin for therapeutic trials in inducing menstruation, etc. Further work will be of great interest in our understanding of the numerous types of derangement of the menstrual cycle.

This survey has included only those clinical uses of estrogens and of progesterone which are well known to give dependable results, or which are based on sufficient knowledge of physiology and clinical states to justify reasonable expectation of results. Numerous more speculative and investigative aspects of such therapy must be left for special studies of each detail. The clinician needs to master fundamental physiological relationships between the pituitary which stimulates the ovaries and the ovarian secretions which stimulate the genital tissues, breast, and nervous system. He can then use these hormones with confidence and with success.

VITAMIN ADVERTISING AND THE MEAD JOHNSON POLICY

The present spectacle of vitamin advertising running riot in newspapers and magazines and via radio emphasizes the importance of the physician as a controlling agent in the use of vitamin products.

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RECORDS AND NEUROPSYCHIATRY*

LAURENCE A. SENSEMAN, M.D.

The Author, *Laurence A. Senseman, M.D., of Pawtucket, R. I. Chief, Neuropsychiatry Division, The Memorial Hospital, Pawtucket, R. I.*

THE PURPOSE of my talk today is to bring to you the importance of Psychiatric records and the outstanding differences between the records of a mental hospital and those of a General Hospital. One of the most important points to be stressed is the legal aspects of the work carried on in a mental hospital. As most of the patients are confined in the institution against their will it becomes necessary to have a legal paper of commitment which will protect the institution, thus giving the personnel the privilege of restraining, when necessary, any individual against their will. This paper is probably one of the most important features of the psychiatric record. This particular form varies considerably with individual hospitals and in the various states. The records as kept by a Psychiatric hospital are much more voluminous than those of a general hospital. This, too, is a necessity as psychiatry takes in the total individual and covers every aspect of medicine hence the detailed reports which are attached to the medical record of a psychiatric hospital.

Recently I wrote to three State Hospitals in Rhode Island, Massachusetts, and Connecticut and three private institutions in this vicinity for copies of their individual records as kept by the institution. I received a prompt reply with the material asked for and it was very interesting to see the close resemblance of these records, as to form and detail. It was also an interesting fact to note that the average psychiatric hospital record requires between 20 and 30 records sheets for a complete work up. This seems a large number to those who are used to writing up brief histories and physical examinations for the medical or surgical problems in a General Hospital. Psychiatric cases require a detailed personal history of the patient from his birth until the time he enters the hospital covering all phases of his life having any relationship to the

development of his psychoses. It also includes a complete family history with emphasis on hereditary factors. It is becoming more important to learn about the birth of the patient, for the knowledge of anoxemia may help us in the understanding of the convulsive disorders, spastic disorders and mental deficiency diseases. It is also important to know about the patient's childhood, his adolescence, his educational background, his occupation, his sexual knowledge and experience, his marital history and also his medical and surgical history. It is very important to know the facts leading up to his commitment and when possible to get a fairly good picture of the personality of the patient before he became sick. Psychiatric examination is important and includes the attitude, behavior, trend of thought, activities, emotional reactions, mental grasps on situations and capacity to remember; all these and others should be included in the psychiatric history.

To present a clear picture of a complete psychiatric case record it should include the following material: a statistical front sheet, copy of the physician's statement or report, an anamnesis, abstracts from other hospitals if the patient has had previous hospitalization; physical examination including a complete neurological examination and usually these records are fill-in-sheets for brevity, admission notes with mental status; progress notes, laboratory data, psychologists examinations, reports of consultants, medical, surgical, orthopedic, neuro-surgical etc., x-ray, weight chart, electroencephalography report, behavior chart, accident reports in case of injury during the stay in the hospital; permit blanks for special treatments which would cover lumbar puncture, electric shock therapy or metrazol, malaria, social service and convalescent clinical notes and correspondence, and if the patient should die there should be a copy of the death certificate and autopsy permit and report if this has been secured and finally a clinical summary sheet. This seems like a rather formidable array of records and no doubt discouraging to the new record librarian but let me emphasize again the importance of such psychiatric records from a legal aspect.

Needless to say the records of an institution are the permanent record of that patient during his

continued on next page

*Presented at the Annual Meeting of the Rhode Island Association of Medical Record Librarians, at Providence, May 14, 1947.

stay in the hospital. They should be written in such a way that five, ten or many years later they can be used as evidence in any court, they can be used for statistical study, they could be used again for reference if the patient is recommitted or if a report is to be sent to another institution. Some times it is very difficult to pick from the record the important features of a person's illness by one who has not written the history of the patient. In the State Hospital records which were received, a summary sheet was a prominent feature of each exhibit. This should include the distinguishing points regarding the patient, the treatment advised and administered, the important laboratory data and any other factors considered important by the physician.

There is another feature involved in mentally sick patients which I would like to point out and which may account for the voluminous records which are sometimes acquired, and that is the fact that patients spend a longer period of time in a mental institution than they do in a general hospital. Therefore, it becomes necessary to re-examine the patient at certain intervals, both from a mental and physical standpoint. Sometimes the patients are in the institution for a period of years and it is very easy to overlook the importance of records in regard to this type of custodial problem. It also brings up the question of progress notes and these may become minimal as time goes on. These progress notes are an important part of the patients record and should include important incidents relating to the patient, yearly physical examinations and mental examinations every six months.

There is a feature of the psychiatric records which I would like to emphasize and that is the confidential nature of the report. Of necessity psychiatrists must ask personal and often times embarrassing questions and the answers recorded. These are not to be used by anyone other than for purposes intended. I find it difficult sometimes to even write down some of the important statements received from the patients because of their very private implication. This entirely confidential material should be kept in strict confidence by the record librarian, the nurses, and by the physicians in charge and if used the name should not be attached to the material in question.

Most doctors have their own way of taking a history and recording the facts which are received. In a psychiatric institution it is sometimes necessary to talk with the patient quite at length without letting them know that you are taking a history on them. This may take a period of days or weeks and an accumulation of data is acquired through these frequent contacts with the patient and it frequently takes considerable time to get to the real core of the problem and the more casual, friendly attitude, the more likely one is to get the information

desired. May I suggest here that the most important contact with the individual patient is during the first few visits, and during this time the patient is gaining confidence in the physician or psychiatric social worker and the data secured at this time may include important facts regarding the illness and should be recorded at the earliest possible moment, as it is very easy to forget what the patient has told you after a short period of time. If the histories are to be accurate too much time should not elapse between the contacts with the patient and getting the information in writing.

To the beginner, psychiatric history taking is a formidable task. It is important that the psychiatrist not become more interested in record keeping than in taking care of the patient. There is a tendency in that direction if one is not very careful. The records are to be used to the advantage of the patient and the physician, not just for a neat appearing record for the record librarian to file away.

Let me quote from an article in the *American Journal of Psychiatry* by Dr. Clarence O. Cheney: "I have thought for some time that perhaps because of our organization of a systematic record-making that the physician, unfortunately for the patient, may get the idea that the record is an end in itself and that making a record completes his observation of a patient and that the record assumes undue importance compared with the actual treatment of the patient." "There is and has been and will continue to be, the need of course, for making records, but unless the record is used for the benefit of the patient or for subsequent patients or for subsequent treatment by other physicians, the record does not make any difference to the patient himself or herself. I have felt that if physicians could feel that instead of having the main end job of making a record that they would get to know their patients, that the main aim would be to know their patients to discuss things with them, to sit down and talk to them in quite an informal, friendly way, without the idea in the physician's mind that he must make a record of anything that is done, that the patient might benefit by such an attitude on the part of the physicians."

The records should be looked upon as an assistance to the doctor rather than a cumbersome burden to be performed. The record librarian should take this into consideration when she completes the records for a patient's chart.

I would also like to quote from the discussion of the same article by Dr. Adolf Meyer: "I have lately gone over an article on statistics which shows a tremendous amount of work back of it and awfully few answers to the questions that I should like to ask. I, therefore, would suggest that for the benefit of the statistical department the cases should have

final summary concerning what the physician himself thinks that case is worth, in the way of teaching for the future, the grouping together of facts and the grouping together of problems." In other words, the records are only of value if they give us the picture of the patient as a whole and if they can convey to another doctor the essential factors and pertinent data regarding the patient who is under their care for a mental illness. Histories, then, do not have to be long and drawn out with a lot of unessential material thrown in to make the record look good. All patients do not need a consultation on the eye, ears, nose and throat, heart and lungs and abdomen. The psychiatrist himself should be able to make a satisfactory examination without the services of a consultant unless there is some specific illness involved for which the psychiatrist is not equipped or prepared to take care of. If we as psychiatrists are to see the whole problem then we should have a thorough knowledge of the other specialties and know when a consultation is important. If this were done more frequently I am sure we would not have the question asked as it is on many occasions, "Are psychiatrists doctors?"

In conclusion may I invite any of you who are interested to examine the psychiatric records which I have for exhibit. These records represent considerable effort on the part of the institution to abbreviate and make as easy as possible, for the physician, a record which will be accurate, statistically valuable and yet represent the patient in the correct perspective, also increasing the possibilities of a complete physical, mental and neurological examination for each individual patient. These records represent many years of experience in record keeping and are probably representative of the leading mental institutions in the country today.

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LOBOTOMY

concluded from page 513

staff hamstrung by the usual public indifference as reflected in legislative inaction. All had been through shock therapy. Improvement in these patients has saved many civil service hours of work. Some have been discharged to home custody; others have been enabled to perform simple tasks of hospital maintenance or have been transferred from the disturbed section to easier surroundings. None are any worse off from the standpoint of society. A few succumbed to post-operative complications, which might have been avoided under better circumstances.

The burden of mental disease is borne by the family and the social group as well as by the individual so afflicted. We are seriously obligated to consider the patient first—but also the relatives and the tax-payer in any program of treatment. Lobotomy can help all three.

Prefrontal lobotomy has been referred to recently in a popular magazine that deals with LIFE in general as "a measure of desperation". I think it would be more accurate to call it a measure for the relief of desperation.

"The crucial decision must be made in each case as to whether a portion of the brain possessing some of the noblest functions of the personality must be sacrificed in order to restore the individual to a more effective existence, whether the effects of frontal lobe deficit will neutralize or accentuate the disharmony already present, whether the individual will be able to think more constructively with less brain at his disposal, whether the relief of the depression and its conversion into euphoria will permit of adequate social adaptation, and whether the individual so treated stands a better chance of survival in the highly competitive society of today than he would with intact frontal lobes and a potentially recoverable psychosis."

This statement was made by Walter Freeman, and I doubt that anyone could express it more effectively.

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THE MEDICAL RECORD

The necessity for medical records needs no justification. Good medical records, however, is a goal sought after not only by doctors, but by hospitals, nurses, jurists, and not least by patients. The distinction between a medical record and a good medical record is one that has slowly but progressively made itself felt. The personal professional experience of every doctor bears ample testimony of this. To the bedside notes of Hippocrates is given the honor of the first written medical record. So it has no claim to novelty. Only within the past quarter of a century has any organized effort by American Medicine been made to bring the medical record up to a level comparable with advances made in other branches of the art.

No more commendable objective could be cited. The responsibility on the part of the individual physician to fulfill this duty is pretty generally recognized. While perfection has by no means been attained, there exists an ever present and ever growing consciousness of the value of a good medical record to the doctor, to the patient, to medicine and its allied sciences and to society as a whole. In general it can be said that the status of the medical record is good and the impetus to achieve further improvement worthy of our never relenting support.

A long road has been travelled since the day that the progress of a patient's hospital stay was written in a bound ledger and filed away to gather dust.

The modern medical records librarian supported by adequate personnel and an accessible library has marked the end of that era. Her place and importance in the present day hospital organization is sufficient tribute to the contribution she has made in emphasizing the value of the medical record. A suggestion of caution, however, appears indicated. From the level of national organization down to the small community hospital, the practicing doctor, who after all is the very essence of a good medical record, has recently become sensitized to a new element in alerting doctors to their responsibility about records. That element is pressure. It must be pointed out that any attempt at co-ercion, particularly when the means to that end is accomplished by the penalty of restricting staff privileges, is fraught with a genuine threat to the unity of our great profession so weighted by other controversies at this time.

There is absolutely no need for the adoption of such methods. It is readily admitted in all local hospitals as well as elsewhere that the standard of our medical records has markedly improved in the past five years. It is to the equal credit of the agencies sponsoring better records and the doctors that this achievement has resulted. The increasing scientific value of the medical record is now so readily appreciated by the average physician, it is certain that further progress will be made without resorting to penalty. Cognizant of the humanness of error and that some within our ranks may not

always produce a good medical record, nevertheless it is entirely unjustifiable, unethical and unmedical to impose or threaten to impose any staff restrictions upon the privileges of a member.

Let us not lose sight of the patient. It is obvious that there has been a tendency to confuse the importance of patients and records, perhaps not intentional but inevitable, in the enthusiasm that has attended efforts to make the medical record a good medical record. While the record was created for the patient, the latter is the pattern upon which the record must be tailored. Reliance upon the traditional integrity of every doctor of medicine will assuredly restore the patient to a position of primary consideration and at the same time not deny the record the relative importance with which time has finally endowed it.

MILLS OF THE GODS . . .

The medical profession of Rhode Island was the first to be involved in the complex problems of a compulsory cash sickness compensation program. Four years experience left us with many questions regarding the medical phases of such a plan still unanswered.

A year ago the House of Delegates unanimously adopted a resolution asking that the proper Council or Bureau of the American Medical Association make a study of the medical phases of existing and

proposed cash sickness compensation plans, and to make such a report available by January, 1947. That resolution was placed before the AMA House of Delegates at San Francisco a year ago. A hearing was held on it by a reference committee, and the resolution was returned to the House of Delegates with recommendation of passage. The House adopted the committee report and the resolution without dissent.

Now, six months after the date when such a report was to be completed, we learn that the matter was not referred to the Council on Medical Service of the AMA until March, 1947! Meanwhile California is laboring under the machinery of a cash sickness compensation plan, and other states might have adopted such a program during recent Assembly sessions. The fact that other states didn't do so is poor justification for the delay in the study.

What is most significant now, however, is the fact that the new cash sickness benefit system for railroad workers goes into effect nationally this month, and every physician, other than those in Rhode Island, and possibly California, is going to learn what happens when a government agency challenges medical diagnoses and disability prognoses.

If the mills of the gods grind slowly, we can only hope that they always grind fine.

JOHN EDWARD FARRELL — DOCTOR OF SCIENCE

DR. JOHN EDWARD FARRELL—thus, henceforth, we may, and assuredly we shall, address the versatile executive secretary of our society and the managing editor of this journal; for at its recent commencement exercises, Providence College, his Alma Mater, conferred upon him the honorary degree of Doctor of Science. To his many friends in the medical profession, which he now serves with such masterful energy, this recognition of his abilities and attainments is no less pleasing than it must be to the officers, alumni and friends of the college whose progress he has done so much to enhance. And while we are offering our congratulations to Dr. Farrell, let us not fail to pay the tribute of our grateful memory to the late Dr. William S. Streker who labored so long and so valiantly to persuade us that we require an executive secretary to assist us in the management of our affairs. While most of us were asleep, Dr. Streker was fully awake to the future needs and the expanding horizon of our profession, and to

him is owing the presence in our midst of the dynamic Dr. Farrell.

Those of us who have observed with interest the developing career of John Farrell have often wondered how a man so young can have done so many things and done all of them so well. Indeed, it may with truth, be said of him, "In every work that he began . . . he did it with all his heart and prospered." But given native intelligence, a liberal education, a creative imagination, sound judgment and tireless effort, there is no field of endeavor from which one may not garner the fruits of honest work. And if, in the future, more honors are in store for John Farrell, as no doubt they are, we can be sure that they will come to him with no more sincere friendship and admiration than he already enjoys within the medical profession of Rhode Island. And so, once again, we congratulate Dr. Farrell and ourselves.

. . . *Committee on Publication and Editorial Board*

CENTENNIAL MEETING OF THE A M A

GUY W. WELLS, M.D.
Delegate from Rhode Island

THE CENTENNIAL CELEBRATION of the American Medical Association was held this year June 9 to 13, 1947, at Atlantic City. Those of us present who had access to the records could look back a hundred years and contemplate the wisdom of the founders and their early successors. The most visionary founder could not have contemplated, however, the One Hundredth Anniversary.

Atlantic City with its huge convention hall and many hotels, all convenient, is almost ideal for this convention generally, and especially this year. Never have so many doctors registered for a meeting—over fifteen thousand—and never has Atlantic City played host to so large a gathering. Atlantic City with its experience in such matters appears to be the only city that could hold such a large convention and with the untiring support of its medical profession formed committees to supervise nearly every phase of convention life.

The Woman's Auxiliary, a very active and important part of the American Medical Association from a functional viewpoint, also held its annual meeting at the same time. Not only their work and interests, but also their presence added a great deal to the success of the convention. This year, for the first time, Rhode Island had official representation in this allied meeting.

The convention hall was packed with both commercial and scientific exhibits, and the medical section alone usually drew more than two thousand doctors a meeting. Dr. Fishbein recalled to the writer that he remembered conventions not much larger than the medical section alone. Bigness or size itself is merely incidental. Secondly it indicates quality, for so many would not attend a mediocre scientific meeting. They were amply justified, for not only were our great medical men reading papers, but more than one hundred distinguished guests from foreign countries and universities were on the platform speaking of their experiences and discussing papers. The chief objective of the founders of the Association, medical education, was not only realized, but rededicated this year.

The House of Delegates met regularly from Monday to Thursday, inclusive, with the exception of one-half day, to permit interested Delegates more time to appear before Committees.

In keeping with the democratic plans of the American Medical Association it is interesting to note that a committee has worked for more than a year revising the Constitution and By-Laws. This revised form was presented to the House of Delegates and must lie on the table one year. During this time Delegates will have the opportunity to study it before a vote is taken to adopt or reject it.

The Committee on National Emergency Medical Service also reported. Their report discussed the nature of the part doctors must take in any future war. They recommended a permanent board for continual study of changing conditions, a permanent up-to-date classification of medical officers, and a better distribution of doctors between armed forces and civilian population, based on the needs of each, and a better system of rotation of doctors. In other words, a more accurate utilization of the medical profession based on a better understanding of the need.

The section on general practice received a good deal of attention, and it was recommended that such a section be established and represented by a Delegate. The representation will probably have to await the adoption of the new Constitution and By-Laws, but the section will have its program at the next meeting. It is quite likely that a mid-winter scientific regional meeting for general practice will be combined with the mid-winter meeting of the House of Delegates.

The complete business of the House of Delegates is recorded in the issues of the American Medical Journal and should be read by every doctor.

It was most gratifying to note the large representation of doctors from Rhode Island, perhaps the largest in history. Doctors Meyer and Elihu Saklad, and Dr. Priscilla Sellman, had an exhibit on Intraspinal Segmental Anesthesia. Dr. Meyer Saklad also discussed a paper given in the section on anesthesiology. Dr. Charles Bradley discussed a paper in the section of pediatrics. Dr. Francesco Ronchese won a first prize in the photographic section of the seventh annual exhibit of the American Physicians Art Association.

The officers for this year are:

President: Edward L. Bortz, M.D., Philadelphia, Pa.

continued on page 558

NATIONAL CONFERENCE OF MEDICAL SOCIETY OFFICERS

(Report by Daniel V. Troppoli, M.D., Secretary of the Providence Medical Association, of the Conference held at Atlantic City June 8, 1947.)

AT THE CONFERENCE of County Medical Society officers one of the first questions asked was whether any plans were being made for a specialty board for general practitioners who live up to progress in medicine.

This question brought forth a lively discussion that took up half of the time of the entire conference. Apparently this topic is uppermost in the minds of general practitioners throughout the country. Dr. R. L. Sensenich, Chairman of the Board of Trustees of the American Medical Association, felt that a specialty board for general practitioners was not the answer to this problem.

There are about 120,000 doctors not certified by any board.

Specialty boards were created to prevent men from setting up as specialists who did not have enough training. They did a good job in this respect. It was not intended that this set-up was to hurt the general practitioner who in some communities does all the medical work. To select out of this hundred thousand general practitioners another ten to twenty thousand as specialists will still leave ninety thousand who will be left out.

Ten years ago machinery was set up to have general practitioners continue postgraduate courses. Some of these courses were financed by outside agencies. Soon these courses were given by specialists outside the scope of the work of the general practitioners, so this did not work out so well.

As a result, however, a physician was added to the staff of the Council on Education and Hospitals. The states did not cooperate with this movement as well as the A.M.A. would have liked. The matter has been submitted to the Council on Education and they will return plans to set up proper courses in the states. Furthermore, recognition will be given for these, and the men will be rewarded by proper credit.

Out of all this may come a unified program which will give equal opportunity to every man in the profession.

Recommendations are already accepted that training is more important than board certification.

The whole subject of medical education should be reviewed. These plans are now underway. Taught by specialists in medical schools, internes in straight service hospitals take residencies in their specialty and then become board members. They have no broad experience. The whole teaching system has to be changed to correct this. Last year the delegates to the American Medical Association passed a resolution that, "Hospitals should have general practitioner sections."

A group in the audience felt that many men who might have gone into general practice would be forced into the specialist group and that a great shortage of general practitioners would result from this.

Every student in medical school has the thought of specializing at some time. In the past he entered general practice first. Many of these practitioners liked what they were doing and continued in it. Others finally after a period of broad experience in general practice went into specialties.

Los Angeles County solved this problem in this manner: The general practitioner group is divided into three categories,

1. *General Practitioner Surgeons.* Men whose record over a period of years showed them able to do major surgery.
2. *General Practitioner Internists.* This group included men who showed ability as diagnosticians.
3. *General Practitioner Group.* These men are not allowed to do major surgery. They are also supposed to call in medical consultants in complicated cases of medicine.

Many felt that the main problem is a shortage of hospital beds. The problem can only be solved by adding hospital beds. Even the prepayment plans won't work unless the beds are available for these patients. The Hill-Burton Bill provides for an annual appropriation of seventy-four million dollars for increasing hospital facilities.

Some of the men present felt that the boards are glorifying the specialist so much that the name "general practitioner" now seems to have a stigma attached to it. This feeling was so great that suggestions were made not to use this term any longer, but to use the term "general physician" or "family doctor."

* * * * *

continued on next page

Dr. L. W. Larson, Member of the Committee on Rural Medical Service, led the discussion on Rural Health.

At least five or six states have formulated definite plans to have rural health conferences. How can young physicians be induced to settle in rural areas? We all recognize the shortage of doctors in rural areas. The local granges recognize this problem and are making good inducements to young doctors to settle in such communities. They know that doctors want good facilities to work with, so local areas are now developing small hospitals for this purpose.

Medical schools now are placing more emphasis on rural practice than formerly. The tendency of rural hospitals to extend their facilities to surrounding rural doctors is also an advance.

All rural county medical societies should do something in this work. They should influence bright country boys to study medicine and practice in their home localities. A local council on health should be formed by rural medical societies and this council should consult with the town or county authorities on these problems. Also, the larger centers should have more contact with rural practitioners.

County medical societies should present subjects that are of interest to the country practitioners. At present some of the groups put on subjects of too scientific a nature that do not attract the rural doctors.

Dr. Norman Scott, Medical Director, Medical-Surgical Plan of New Jersey discussed prepayment medical plans for rural areas. Since these prepaid plans must necessarily work with groups, the rural groups must be well organized. These groups could include farm cooperatives, farm bureaus, and farm granges. As a matter of fact whole rural communities could be enrolled. The Louisiana Surgical plan is incorporating whole rural communities.

* * * * *

Dr. A. M. Mitchell, of the Council on Medical Service of the American Medical Association led the discussion on Public Relations. He submitted a report on the medical public relations in the District of Columbia as an example. This report showed that in 1940 the District of Columbia Medical Society devoted 10 per cent of the time to medical relations. Now it is putting in 25 per cent of its time to medical relations to keep the doctors informed, because if the doctors do not know, they cannot spread the information to their patients.

Medical publicity involves proper relationships with the newspapers. The medical profession

needs the cooperation of the newspapers. Releases for the newspapers should be prepared to avoid misquoting. This method also furnishes the reporter with information to answer his questions.

Avoid unnecessary controversies, particularly small petty ones. In their legislative programs the societies must have enterprise, friendship, vision, courage, and leadership.

* * * * *

The American Medical Association Committee on Motion Pictures sent an announcement that medical and health films of the A.M.A. are loaned to county medical societies on request. The only charge made is for transportation. They also have a series of health films to be shown to lay audiences. They have a source list at A.M.A. headquarters, and a letter to them will tell any doctor where he can get the desired film.

The reviews of motion pictures which have appeared in the Journal of the American Medical Association will soon be published in booklet form and sent to local medical societies. They describe the length, content, quality, and subject of the film. A film forum will start this fall at the A.M.A. Three or four films a month will be previewed by teachers and these reports will be transmitted to state societies.



This sunset on the Canadian vastness, taken by Dr. F. Ronchese, July 16, 1946, from the east-bound observation car, won first prize at the 7th annual meeting of the American Physicians Art Association, held in conjunction with the centenary celebration of the American Medical Association, Atlantic City, June, 1947.

THE EDUCATION OF THE NURSE

The following discussion of the education of the nurse offering some interesting observations on the nurse problem of today was submitted by a Rhode Island physician with a deep background in medical and nursing problems in this State for many years. The Editors considered the communication an excellent presentation worthy of general reading, and therefore publish it with the permission of the author, but with his name withheld from the title heading.

—*The Editors*

THE REPORT on the "Nursing Problem" by a Special Committee of the American Surgical Society, published in the A.M.A. Journal (April 12th—page 1168) with editorial comment, deserves notice in all Medical, Hospital, Nursing, and indeed lay press of the country. It is a convincing statement, to which we refer every one interested for careful study.

The Report states simply, clearly and temperately, the basic causes to which may be credited, in large part, the present dearth of nursing personnel, with its definite drop in morale and efficiency, from which the Hospitals and public now suffer. Its final Resolution is to the point and will help to meet the *present* situation, i.e., "Resolved that it urge the immediate establishment of short courses for the training of bedside nurses".

However, we believe this Report, with its clear discussion of the subject, opens the way for possible action in correcting, not only the present difficult nursing problem, but the mistaken trend in nursing education which has existed for many years past, that over-emphasis of "intellectual and scientific" rather than common sense, practical training for those who would follow this noble profession.

Several National Nursing Groups (named in the Report) which for years past have controlled nursing education and so the Nursing Schools in this country, have so exaggerated this "intellectual" requirement of the profession that they have well nigh lost sight of the primary, human, practical purpose for which the nurse is trained and needed, i.e., the bedside care of the sick patient. They have striven to persuade Hospital, Nursing Schools and personnel, and finally themselves, that nursing is

one of the learned professions, which it is not and should glory in not so being, since it is one of the great humanities.

As a possible solution of this problem, becoming ever more serious as time passes, we offer the following, well realizing that a start made now can produce results only in the distant future:

Establish in the Nursing Schools a basic course of 1½ years for all pupils, upon the satisfactory completion of which the student graduates with a diploma (R.N.). We emphasize a "single" basic course, as we are convinced 2 courses, one short for so called bedside nurses and another longer for R.N.'s. in the same School would be complicated, confuse the public and not be satisfactory. Also do we believe that a good practical 1½ years course for students of high school diploma grade, is long enough to train them for the duties required of the R.N. Such a course will be devoted largely to practical instruction in the care of the sick medical, surgical, and other patient, with all that this implies, and with a minimum of didactic work. From this whole undergraduate body of students, some will decide they wish to go further and specialize in a branch of nursing which appeals to them, such as Surgery, Obstetrics, District, Industrial or Mental work; these students will be required to study for another six months or perhaps a year.

To enroll in this advanced course, the requirements should be *very* strict; broadly speaking, an exceptionally fine record in the regular 1½ year course with definite promise of success in more specialized work. Such restriction would eliminate mediocre personnel in those advanced nursing groups, which bear the burden of responsibility in specialized branches of the profession, as well as in nursing education. To such nurses a second diploma should be awarded (R.N.S.S.—Special Surgical, R.N.S.N.—Special Neurology) and they would command higher pay.

It is agreed by many experienced physicians as well as nursing superintendents, etc., that the periods of time, above suggested, should be sufficient for basic training in the two grades of nurses as described. Finally, there should be no grade of nurse other than the two above described recognized or certified by the State authorities.

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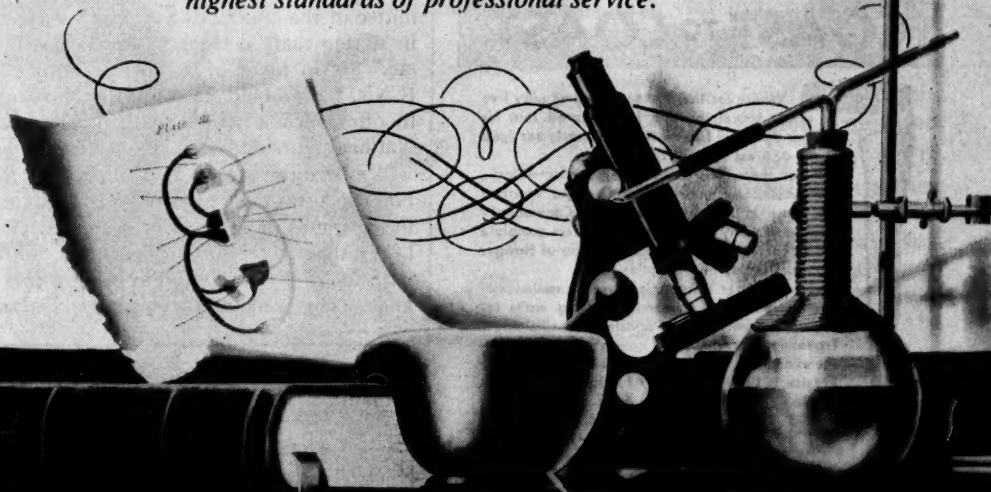
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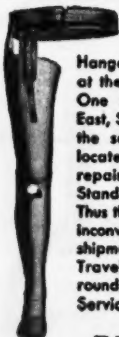
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RHODE ISLAND MEDICAL JOURNAL

EDUCATION OF THE NURSE

concluded from page 526

It seems that such a plan would present several advantages—

- (1) It would attract more young women than at present to the Nursing Schools. (Many now are deterred by the prospect of three years of training.)
- (2) It would relieve the student of much present didactic study, unnecessary and quickly forgotten, and so give more time for instruction in caring for the sick patient at the bedside.
- (3) It would stimulate ambition to become an advanced student.
- (4) It would enable the advanced student to concentrate on the specialty of her choice and become truly expert.
- (5) It would eliminate the present unsatisfactory and confusing situation of several grades in nursing service, i.e.—R.N., Practical Nurse, Nurses' Aides, and perhaps others whose specific duties are now a matter of debate.

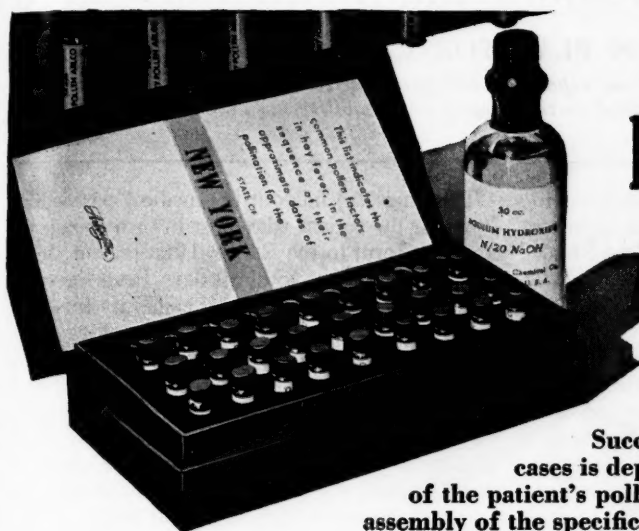
It is manifest that the large group of so called Practical Nurses (many of these excellent) now actively working, would not come under such a plan, unless they enter for the 1½ year course in a nursing school, for which many would be beyond the age limit. For such, special provision should be made.

The several dominant national nursing groups, referred to above, would probably oppose such a plan, but should be urged to consider it in a co-operative spirit.

If, as is doubtless the fact, the Reporting Committee of the American Surgical Society is correct in stating that "doctors, hospital superintendents, etc." are in favor of a short practical course for R.N's. they should influence the Nursing Schools to offer such a course, without approval of the National Nursing bodies, if such cannot be gained.

We here preach not revolution but evolution, a non-conformist doctrine if you will, but one long in the minds of the best informed people. Where better than in this little historically non-conformist State of Rhode Island to bring it into the open and so start a move for bigger and better nursing.

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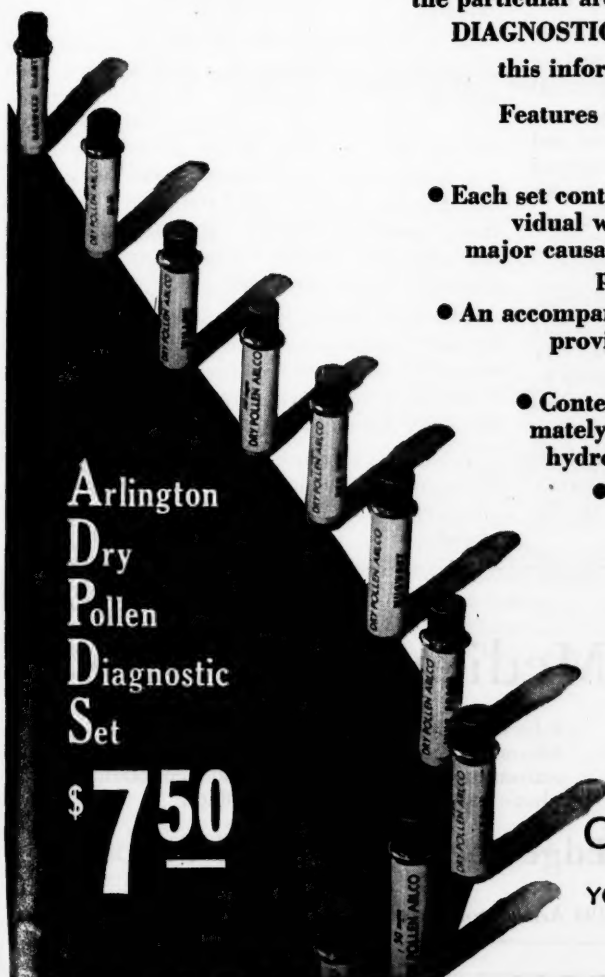
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CASH COMPENSATION PLAN FOR RAILROAD WORKERS

(All physicians should read this brief report on the plan started July 1 for railroad employees as the program entails medical certification of any disability, as in the R. I. Cash Sickness plan.)

RHODE ISLAND physicians, already educated to some extent to the system of cash sickness benefits as the result of the operation of the Rhode Island Cash Sickness Compensation plan, now face another similar program for railroad workers.

Effective the first of this month operation was started in accordance with amendments made last year to the Railroad Unemployment Insurance Act whereby partial compensation for wage loss due to disability on the same basis as that due to unemployment will be available for more than two million railroad workers throughout the country. The system is administered by the Railroad Retirement Board which administers the entire railroad unemployment insurance program.

The fund from which payments will be made is created by the railroads, and the plan will be somewhat of a mail order insurance in that all claims for benefits have to be filed at the board office in New York within nine days from and including the first day the claimant is unemployed due to illness. The railroad workers are not under any other program, such as the Rhode Island unemployment and cash sickness plans.

Medical Certification

As is the case with the Rhode Island cash compensation plan, the railroad worker must secure himself the proper forms from his employer (the railroad) and must have a medical examination by his personal physician completed as part of the requirement for benefits. The railroad worker continues as any other private patient of the physician and the railroad retirement board makes no provision for the payment of the physician's fee for the medical examination.

The physician fills out the medical certification form for the patient who must in turn submit the complete form to the Railroad Retirement Board in New York City within 9 days from the onset of the disability, otherwise his eligibility for benefits is jeopardized. In view of this ruling every physician should, whenever possible, allow the patient to send the medical form which is attached to the complete form to be filed, as otherwise there may be inadvertent delay which may prove costly to the patient-claimant. However, if the physician does not wish the patient to have the medical report and diagnosis, then he should detach it from the form and mail it directly to the board office himself.

As is the problem with the Rhode Island Cash sickness medical certification, the physician is faced with the task of providing a disability prognosis. After the initial claim additional benefits may be allowed for succeeding 14-day periods for a predetermined time as indicated by the medical evidence on the doctor's initial statement. But in the case of continuing illnesses supplemental information about the patient's illness may also be requested from the physician.

When the Board has occasion of question the medical certification it reserves the right to refer the claimant to an impartial medical examiner. Three such examiners have already been designated for Rhode Island.

Additional information about the program may be secured by any physician from the Railroad Retirement Board, 1802 P.O. Bldg., Boston, Massachusetts.



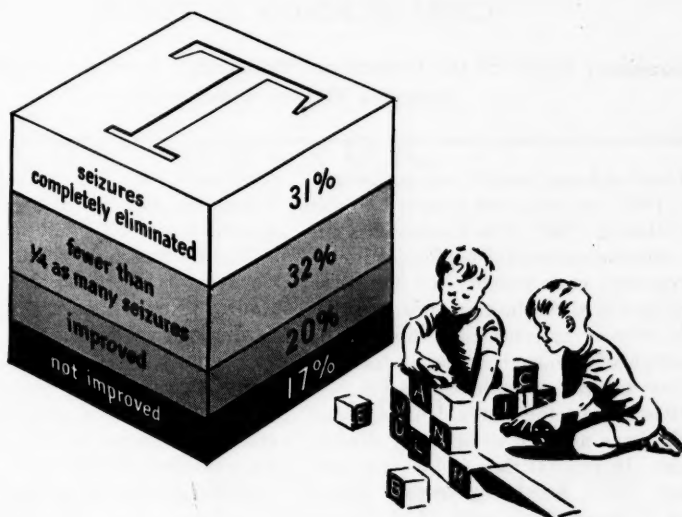
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Here's new evidence of the effectiveness of Tridione in the treatment of petit mal. In a recent study, Tridione was given to 166 patients suffering from petit mal (pyknolepsy), myoclonic jerks or akinetic seizures.¹³ This group as a whole had received but mediocre benefits from other medicaments. With Tridione, 31% of the 166 became free of seizures; 32% had fewer than one-fourth of the previous number of seizures; 20% improved to a lesser extent; 13% remained unchanged, and only 4% became worse. *Thus 83% showed improvement.* In some cases the seizures *did not return* after Tridione was discontinued, the longest seizure-free period thus far being 18 months. Studies also have shown that Tridione is of benefit to certain psychomotor patients when given in conjunction with other antiepileptic drugs.¹² Tridione is available through your pharmacy in 0.3-Gm. capsules and in pleasant-tasting aqueous solution containing 0.15 Gm. per fluidrachm. Capsules in bottles of 100 and 1000; solution in 1-pint and 1-gallon bottles. If you wish to know more about Tridione, just write to ABBOTT LABORATORIES, North Chicago, Illinois.

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CASH SICKNESS BENEFITS

(From supplementary report of the Council on Medical Service to the House of Delegates of the American Medical Association)

A STUDY of cash sickness benefits was authorized in July, 1947, but was not referred to the Council until March, 1947. The Council has inquired briefly into the status of disability insurance providing temporary cash benefits for time loss due to non-occupational disabilities. We find that there is much controversy concerning this type of insurance, particularly when it comes about as a result of either federal or state legislation. At the present time two of the states, Rhode Island and California, have adopted compulsory disability benefit laws. In general they follow the same pattern. They differ, however, in that Rhode Island sets up a monopolistic state fund for the purpose of supplying benefits, while the California law permits either the employer or a group of employees to establish a voluntary plan as a substitute for coverage under the state plan. Many defects seem to have become apparent in the Rhode Island program, and it seems to be the consensus that it provides only a negative lesson in that it shows certain features not desirable in a law but gives no experience to prove that even with these eliminated, its operation would be satisfactory. The California plan has not provided sufficient experience to determine its worth.

The Council finds that some thirty-two "cash sickness" bills have been introduced this year in the legislatures of thirteen states. Twenty-two of

these bills have failed to pass, one passed both houses but was vetoed by the governor, and nine are still under consideration.

The Council also points out that the action of Congress in amending the recent provision of the Railroad Retirement Act to provide disability benefits for railroad employees will likely serve to focus and intensify the interest of state legislators in compulsory disability benefit laws. There has, of course, been a rivalry between the state and federal governments in the field of unemployment compensation benefits and a renewed drive for state legislation may well be expected. If this drive materializes the state medical societies will need aid in devising policies and this will require a knowledge of developments under existing programs.

We must not forget that this type of compulsory program may well lead to expansion of social security legislation along the lines suggested by Senators Murray and Wagner and Representative Dingell. Therefore, its benefits and defects must be reviewed in the light of principle as well as temporary accomplishment. The Council mentions this preliminary study of cash sickness benefits to call attention to its importance and to inform the Delegates that a detailed study will be made so that the State Medical societies will be in a position to meet possible future legislation.

VETERANS' ADMINISTRATION HOME TOWN MEDICAL CARE PROGRAM

UNDOUBTEDLY most of the Delegates are aware of the Veterans' Administration Home Town Medical Care Program. Under this program the veterans were to receive medical care for service-connected disabilities from physicians of their own choice, physicians were to serve for fees agreed upon through their state medical societies, and every effort was to be made to provide the veterans with the same medical care received by civilians. Up to the present time some thirty-eight state medical societies have worked out agreements with the

Veterans' Administration for the purpose of providing the veteran with the same care he would receive as a private patient. To this decentralized, free choice program the Veteran's Administration agreed.

There are now indications that new factors have arisen that have resulted in the Veterans' Administration altering its policy. It would seem now that its policy is to set up more and more clinics manned by Veterans' Administration doctors, and require veterans to go to such clinics

continued on page 536

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VETERANS HOME TOWN CARE

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where available. Further, the Veterans' Administration has prepared a schedule of fees, which while supposedly an attempt to arrive at a standard nomenclature, does contain a maximum fee for each service and has all of the earmarks of a nationwide schedule of fees.

The Council recommends to the House of Delegates:

1. That the Council on Medical Service be authorized to set up a conference for the purposes of arriving at a definite policy with regard to the Veterans' Administration Home Town Medical Care Program.
2. That representatives from each of the state medical societies and representatives of the Veterans' Administration be invited to this conference to present their views, experiences and opinions.
3. That following this conference, the Council on Medical Service in collaboration with the Board of Trustees and representatives selected by the State societies be authorized to meet with representatives of the Veterans' Administration to effect solution of any existing problems.

NATIONAL ESSAY CONTEST

Announcement has been made of the winners of the Association of American Physicians and Surgeons' National Essay Contest for Junior and Senior High School students on the subject, "Why the American System of the Private Practice of Medicine Gives the Finest Medical Care the World Has Ever Known." They are as follows: First prize of \$1,000 awarded to Miss Jean Downhour, Benchland, Montana; Second prize of \$500.00 awarded to Dick Brandow, Bradford, Pennsylvania; Third prize of \$100.00 awarded to Miss Bettye Eccles, Gulfport, Mississippi.

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HOSPITAL ASSOCIATION OF RHODE ISLAND

REPORT OF ACTIVITIES

Furnished by the Staff of the State Hospital for Mental Diseases

Hospital Association Meeting

The June meeting of the Hospital Association of Rhode Island was held at the Westerly Hospital. Preceding the business meeting, Miss Helen M. Blaisdell, Superintendent, conducted the members through the Hospital. The members of the Association were served a delicious shore dinner at The Willows, in Charleston, following the meeting, as guests of Miss Blaisdell.

Medical Staff Changes

Dr. John A. Paterson, Senior Physician on the staff of the State Hospital for Mental Diseases for the past eight and one-half years, resigned as of June 15th to accept a position on the staff of the Veterans Administration Hospital at Togus, Maine. Dr. George L. Wadsworth, former Assistant Superintendent at the State Hospital for Mental Diseases, has been Clinical Director of the Neuropsychiatric Service at the Togus Veterans Hospital since November, 1946.

School of Nursing

On September 1st, 1945, the State Hospital for Mental Diseases School of Nursing received the first class of student nurses for a thirteen-weeks course in psychiatric nursing. The course has continued, except for one period due to the absence of an Educational Director. There are eleven students in the present class—three from the Memorial Hospital, Pawtucket; three from the Newport Hospital; and five from the Roger Williams General Hospital. It is planned to gradually increase the number of schools represented and the total number of student nurses enrolled.

New Pay Plan

A new salary schedule for State Civil Service attendants and nurses has been effective since February 16th. Starting July 1st the majority of the other State employees will receive salary increases under a new pay plan developed by the State Department of Civil Service. Incorporated in the new pay plan is a new maintenance plan under which all items of maintenance will be paid for on a cash basis, following a schedule of values developed by the State Department of Civil Service and the State Department of Finance.

Hospital Survey and Construction Act

The Governor has signed the State Hospital Survey and Construction Act which carried an appropriation of \$10,000. Provisions in this bill are in accordance with the requirements of the Federal Hospital Survey and Construction Act.

World War II Veterans

A recent study of admission of World War II veterans to the State Hospital for Mental Diseases reveals that 173 veterans have been committed to the Hospital and that all except 44 have been released, including 34 for transfer to neuropsychiatric hospitals for veterans. Of the 129 released from the Hospital, 17 have been recommitted. There have not been any deaths in this group, as might be expected of patients in this age group.

Summer Workers

The Unitarian Workcamps, of Boston, Massachusetts, have added employment at the State Hospital for Mental Diseases as one of their service projects for college students, applicants being accepted on the basis of genuine interest in hospital work. The work camp offers a balanced program of work, education and recreation. It is non-sectarian and interracial. Similar work camps have been sponsored by the Mennonite Church Agency in recent years, and their assignments at the State Hospital for Mental Diseases have been highly successful.

Admission and Release of Patients

The majority of patients at present come to the Hospital on a Department of Social Welfare order. Applications for admission are completed by two licensed physicians and a member of the family. These are submitted to the Department of Social Welfare, 40 Fountain Street, Providence, Rhode Island. An order is issued which authorizes the Hospital to receive the patient. This is brought to the Hospital with the patient by the family. Such application forms are available at the Department of Social Welfare, Providence, at the State Hospital and in the office of the Director of Public Welfare in most communities.

There is a growing trend to admit patients on a voluntary basis. Any person who comes to the Hospital requesting treatment is eligible for admission on a voluntary basis if he shows knowledge

continued on page 540

On the Plus Values In Variety Meats

Variety meats—as the meat industry terms liver, kidney, heart, thymus (sweetbreads), and tongue—are at least as nutritionally desirable as muscle meat. In fact, in some respects certain organ meats are superior.

They provide the indispensable amino acids in the same advantageous complete assortment as muscle meat. Hence their protein is of the same high biologic value, capable of meeting every protein need of the organism. Quantitatively their protein content is approximately equal to that of muscle meat.

For hemoglobin synthesis, liver and kidney have been found superior not only to all other protein sources so far studied but also to muscle meat itself.

All organ meats are good sources of the B-complex vitamins. Some of them, such as liver and kidney, are especially rich in niacin. Liver is also an excellent source of vitamin A.

Apparently the vital role these organs play in the functioning of the animal body is reflected in the valuable contribution they can make to human nutrition. Their frequent inclusion in the human dietary—during disease as well as in health—is amply justified.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



AMERICAN MEAT INSTITUTE
MAIN OFFICE, CHICAGO . . . MEMBERS THROUGHOUT THE UNITED STATES

HOSPITAL NOTES

concluded from page 538

of the nature and location of the Hospital and is willing to sign an agreement that he will give notice in writing three days before he leaves. Voluntary admission is encouraged whenever possible, as this enables the patient to feel that he is an active participant in the treatment plan.

A District Court commitment frequently constitutes the most expedient means of arranging for admission of a patient who has shown behavior disturbing to the community. However, with patients whose behavior has not led to contacts with the police it is desirable to avoid a court commitment. Department of Social Welfare order or voluntary admission enables the physician to arrange for hospital care without the need of a court contact, which is greatly resented by many patients.

During the year, July 1, 1945, to July 1, 1946, 827 patients were admitted. Department of Social Welfare orders accounted for 515, District Court commitments for 237, voluntary admissions for 61, Superior Court commitments for 10, and voluntary narcotic admissions for 4.

Release from the Hospital is at the discretion of the Superintendent. In practice, a patient is

RHODE ISLAND MEDICAL JOURNAL

released from the Hospital whenever the maximum benefit from hospital care has been achieved or when a suitable plan for his care is worked out with the family. This may be in the home of a relative, in another hospital, in a convalescent or boarding home. It does not depend upon complete recovery. The family's request to remove a patient is rarely refused. This is done, however, when necessary to protect the patient or others from serious results of irresponsible behavior. During the year, July 1, 1945, to July 1, 1946, 721 patients returned to the community.

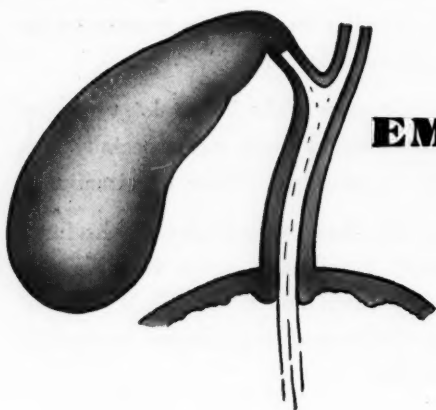
IN OLNEYVILLE IT'S . . .

McCAFFREY INC.

Druggists

19 OLNEYVILLE SQUARE

PROVIDENCE 9, R. I.



EMPHASIS ON FLOW—

Decholin



3¾ gr. tablets. Boxes of 25, 100, 500 and 1000;
powder 25 Gm.

Fluidity of the bile is the factor which determines success in removal of thickened and purulent material from the bile passages. Decholin (chemi-

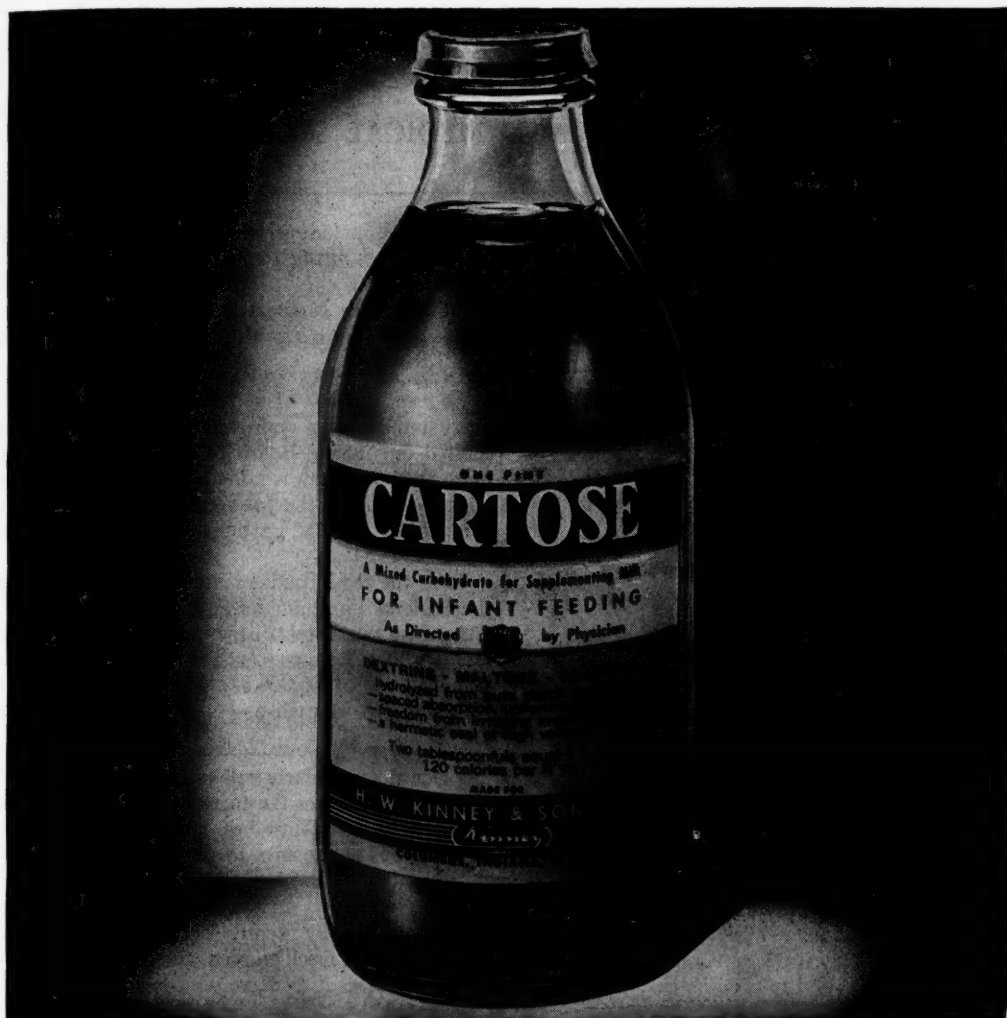
cally pure dehydrocholic acid) stimulates the liver cells to produce a thin, easily flowing bile, which flushes the ducts, and promotes drainage.



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ELKHART, INDIANA



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Specification of CARTOSE* as the mixed carbohydrate for infant feeding formulas provides ease and economy of use. The liquid form of this milk modifier permits rapid, accurate measurement, thereby avoiding waste.

Double protection against contamination is afforded by: (1) the narrow neck of the bottle, preventing spoon insertion, and (2) the press-on cap, assuring effective resealing.

CARTOSE supplies nonferment-

able dextrans in association with maltose and dextrose . . . a combination providing spaced absorption that minimizes gastrointestinal distress due to fermentation.

Available in clear glass bottles containing 1 pt. • Two tablespoonfuls (1 fl. oz.) provide 120 calories.



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Mixed Carbohydrates

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trademark

COLUMBUS, INDIANA

ANNUAL REPORTS — 1946

THE RHODE ISLAND MEDICAL SOCIETY

ANNUAL REPORT OF THE
SECRETARY — 1947

In view of the fact that the membership of the Society has been fully informed through the JOURNAL of the society of all actions taken by the House of Delegates, and of important committee actions, a resume by the Secretary of the activities may rightfully be omitted from this report.

During 1946 the Society attained its highest enrollment in its history with a total of 761 Fellows on the roster. This consistent growth in membership at a time when organized medicine is faced with many vital problems may be taken as evidence of the increasing interest and support of the many activities of the Society in behalf of the profession and of the public generally.

The Council has met regularly and has given conscientious consideration and study to every problem placed before it. It has served as the clearing house for the many activities carried on by or referred to the Society.

The Board of Trustees, with approval of the Council, effected needed repairs to the Library building and purchased fire insurance consistent with today's valuation of the building and contents.

The executive office continued its invaluable assistance to the officers, the Council, House of Delegates, and the various committees of the Society, in addition to the many services it has rendered to individual members, and to the public.

Respectfully submitted,
MORGAN CUTTS, M.D.

May 7, 1947

ANNUAL REPORT OF THE
TREASURER — 1946

The complete record of all the finances of the Society, and the disposition of all funds, constitutes the actual report of the Treasurer. However, as a mere recital of figures in balance might prove tedious reporting for you to hear, I offer this brief summary by way of explanation of the work of the Treasurer for the Society. The complete statistical report is available, and I shall be pleased to read it in detail if it is the wish of any member of the House.

Summary of 1946 finances:

The Society started the year with a cash balance of \$6,807.01.

Receipts, including annual dues, payments for exhibit spaces at the annual meeting, advance payments on 1947 exhibit spaces, contributions from the Providence Medical Association, and miscellaneous donation (use of building, etc.) amounted to \$21,948.85.

To meet the cost of necessary repairs to the Library building, as approved by the Council and carried out by the Board of Trustees, a total of more than \$8,300 was added to the General Fund by transfer from the JOURNAL Fund, the Endowment Fund, and a Participation Account established in 1934.

Thus the total funds created over the year into the General Fund amounted to \$35,167.19.

Against this a total of expenses of \$29,100.62 was paid out, leaving us at the end of 1946 with a cash balance of \$6,066.57, which is slightly less than we had as cash assets at the beginning of the year.

I would particularly call to the attention of the House of Delegates the fact that for the first time in many years the Board of Trustees has been able to make needed repairs to our building. A careful appraisal of the building by our architect revealed some very serious construction problems that entailed costly repair. The entire roof had to be repaired, the brick pointed, and every precaution taken to offset the damages of years standing, damages which resulted in leaks that caused disfiguring of the auditorium and the book stack walls. The exterior, as far as the roof is concerned, is now in good condition. Also, the auditorium has been painted.

In addition we have had a careful re-valuation of our property and have purchased insurance to protect the Society against fire and other hazards to our property. The sidewalk about the building, put in two years ago, entailed another expense against the 1946 account. These three items alone, repair, insurance, and the sidewalk, aggregated more than \$7,100.

To meet these expenses our Endowment Fund has been depleted except for some stock amounting to \$2,100 in value. The Participation account, so called, a reserve fund set aside in 1934, has been used, and the reserve fund of the JOURNAL has been heavily drawn against.

continued on page 544

Now

FOR GREATER EASE OF ADMINISTRATION

Parenamine

Parenteral Amino Acids Stearns

IS SUPPLIED IN

6% sterile solution

- In Convenient One-Liter Bottles
- Ready For Immediate Use

An improved acid hydrolysate of casein, fortified with *dl*-tryptophane, *dl*-methionine and glycine, PARENAMINE 6% is a complete mixture of all the amino acids essential for humans plus other amino acids native to casein . . . an excellent substitute for dietary protein.

Sterile, pyrogen-free non-allergenic, pH 5.5, PARENAMINE 6% has an exceptionally low ash (sodium ion) content and is virtually chloride-free. Clinical studies indicate that thrombosis rarely occurs.

FOR USE whenever dietary measures are inadequate for maintaining an optimal nutritional status . . . for prevention and correction of protein deficiency . . . to compensate for abnormal losses of body proteins . . . to fulfill increased demands.

SUPPLIED in one-liter bottles, adaptable to any type of intravenous delivery set-up . . . 60 Gm. of amino acids (the average adult daily requirement) in 1000 cc. of distilled water.

PARENAMINE 15%—acid hydrolysate of casein fortified with *dl*-tryptophane—continues to be available in 100 cc. bottles.

Fredrick Stearns & Company Division

DETROIT 31, MICHIGAN

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Windsor, Ontario Sydney, Australia Auckland, New Zealand

Trade-Mark Parenamine Reg. U.S. Pat. Off.



TREASURER'S REPORT

continued from page 542

As a result the Council named a committee of its members to study the future needs and the financial policies of the Society. On the basis of the report of that Committee it was recommended that the dues for 1947 be \$40.

At the present time when this report is being submitted to the House, the Board of Trustees is securing bids for the painting of the reference room and the stair halls, as well as the Miller Room and the executive offices, and it is also securing estimates for new lighting in the Library to replace the present fixtures. It also hopes to improve the facilities of the Reference room for the benefit of the membership of the Society.

The interest from the various Special Funds offer a means to secure some new books. It is the hope of the Library Committee and the Board of Trustees, I know, that additional funds be made available in the future to allow for the purchase of the newest texts and reference studies available.

All these projects added to our annual operational expenses will continue to leave us little for a reserve fund. But as a non-profit organization our purpose is service to our membership, and to the public, and the responsibility is one for every Fellow of the Society.

Our books are in order for the year 1946, and a statement of finances is submitted herewith.

CHARLES J. ASHWORTH, M.D.

Treasurer

May 7, 1947

Summary

Total Cash Income (all sources)	\$35,167.19
Total Expenses	29,100.62
Cash Balance	\$ 6,066.57
* * * * *	
General Fund (January 1, 1947) Cash	\$ 6,066.57
Treasury Bonds	2,000.00
Total	\$ 8,066.57
* * * * *	

Receipts

Cash balance, January 1, 1946	\$ 6,807.01
Annual dues	\$13,882.62
Interest from Investments	796.30
Payments, 1946 annual meeting exhibits	652.50
Payments, 1947 annual meeting exhibits	1,050.00
	\$ 6,807.01

RHODE ISLAND MEDICAL JOURNAL

Payments, 1946 annual meeting, dinners	1,120.00
Payments, Members of Council for dinners at Council Meetings	120.00
Providence Medical Association	4,069.09
Miscellaneous (donations, reimbursements, etc.)	258.34
	\$21,948.85
Transfer of funds to General Account:	
Charles F. Gormly Fund \$	102.51
Endowment Fund	4,638.80*
Participation Account	670.02
Rhode Island Medical Journal	3,000.00
	\$ 8,411.33*
TOTAL	\$37,167.19*

* \$2,000 in U. S. Treasury Securities, Series G

Expenses

Annual Meeting (including dinner payments)	\$ 2,337.42
Books	181.41
Committee expenses	283.82
Donations and dues	200.00
Electricity	43.36
Fuel	775.86
Gas	38.96
Insurance (Fire, liability, property damage, annuity)	1,744.72
Internal Revenue (withholding taxes)	1,223.96
Legal expenses	150.00
Library expenses, miscellaneous	433.64
Miscellaneous expenses, Society and executive office	398.11
Office supplies and equipment	258.91
Printing and postage	424.79
Refunds on dues to physician-veterans	404.20
Repairs to Library Building	4,626.68
Salaries	13,390.28
Sidewalk replaced	762.00
Telephone	215.87
Travel (officers and delegates to AMA)	1,206.63
Total	\$29,100.62

continued on page 546

TYROTHRIN



Concentrate

excellent topical antibiotic!

"For topical application . . . Tyrothrin is an excellent agent . . ."

TYROTHRIN is rapidly bactericidal—even in high dilutions—and exerts prolonged contact at the site of application. Low surface tension permits penetration of **TYROTHRIN** into minute tissue crevices. This remarkably effective antibiotic is relatively stable and possesses low toxicity when applied topically. **TYROTHRIN** is applied by instillation, irrigation, wet dressing or spray in treatment of gram-positive localized infections.

Indications: Superficial indolent ulcers, abscesses of the skin and soft tissues, chronic purulent otitis media, mastoiditis, sinusitis, empyema, certain types of wound infections.

TYROTHRIN CONCENTRATE (*For Human Use*), Sharp & Dohme, is supplied as follows: (1) Package containing 1-cc. ampul of a concentrated solution of **TYROTHRIN**, 25 mg. per cc., and a vial containing 49 cc. of sterile, distilled water for diluting the concentrate before use; and, (2) 10-cc. and 20-cc. vials of **TYROTHRIN CONCENTRATE**, 25 mg. per cc. Sharp & Dohme, Philadelphia 1, Pa.

*Int. Abst. of Surg. 83:1-12 July 1946

TREASURER'S REPORT

continued from page 544

SPECIAL FUNDS

J. W. C. ELY FUND

A memorial fund established in 1912 by the son and the granddaughter of Dr. J. W. C. Ely, in the amount of \$1500, to be called the J. W. C. Ely Fund and the income from which was to be used for periodicals.

52 shares, R. I. Public Service Company	\$1,587.30
Interest	104.00
	<hr/>
	\$1,691.30
Paid to R. I. Medical Society for periodicals.....	104.00
	<hr/>
Balance	\$1,587.30

* * * * *

ENDOWMENT FUND

Started in 1912 when the Trustees (of the Fiske Fund) announced that they had voted to take the remuneration allowed them by the will, i.e., 2/12 of the annual income, amounting that year to \$69.69, and to present this sum to the Rhode Island Medical Library to be the foundation of a "maintenance fund" for the support of the Library Building.

16 shares, National Bank of Commerce	\$1,200.00
Interest	48.00*
74 shares, Providence Gas Company	906.50
Interest	48.10*
Peoples Savings Bank.....	2,599.16*
Interest	39.01*
U. S. Treasury Securities, Series G.....	2,000.00**
Interest	25.00*
	<hr/>
Total	\$6,865.77

*Paid to Rhode Island Medical Society for building repairs \$2,759.27

**Transferred to General funds to compensate for expenditures for building repairs 2,000.00

\$2,106.50

* * * * *

E. M. HARRIS FUND

Established in 1921 by a donation of \$5000 by Dr. E. M. Harris for "upkeep of the Library Building".

25 shares, Consolidated Edison Company.....	\$2,346.88
Interest	125.00*

RHODE ISLAND MEDICAL JOURNAL

74 shares, Nicholson File Company	2,719.00
Interest	259.00*

Total \$5,449.88

*Paid to R. I. Medical Society for building repairs 384.00

Balance \$5,065.88

* * * * *

FRANK L. DAY FUND

Established in 1927 by a donation from the estate of Dr. F. L. Day, to be utilized for the purchase of books.

3000 Canadian National Railway Company	\$2,979.75
Interest	202.50
Industrial Trust Company, checking account	693.62

Total \$3,875.87

Paid for medical books..... 111.53

Balance \$3,764.34

* * * * *

HERBERT TERRY FUND

Established in 1928 by a donation of \$2000 from C. B. and C. H. Kenyon, in memory of Dr. Herbert Terry, for the purchase of books and periodicals and for the binding of same for the Library.

96 shares, Providence Gas	\$1,152.00
Interest	62.40*

Total \$1,214.40

*Paid to R. I. Medical Society for books..... 62.40

Balance \$1,152.00

* * * * *

JAMES R. MORGAN FUND

Established by a donation of \$500 in 1929 to be used for current expenses.

43 shares, Providence Gas Company	\$ 526.75
Interest	27.95*

Total \$ 554.70

*Paid to R. I. Medical Society for current expenses 27.95

Balance \$ 526.75

* * * * *

continued on page 548

Are
these
YOUR
patients
?



The man who must be careful of his diet... yet requires plenty of rich, wholesome milk?



The under-weight teen-ager, who lacks "pep"...who needs a pleasant yet dependable source of carbohydrates, proteins, fats and vitamins for energy and proper growth?



The youngster who demands lots of calcium and phosphorus for the building of sound bones and teeth?

Then you'll be interested in these facts on Hood's Homogenized Milk.

In homogenized milk the cream globules are broken up into tiny particles (1/200th their original size) and distributed evenly throughout the entire bottle.

The last drop is just as rich in calcium, phosphorus and vitamins as the first.

When you suggest Hood's Homogenized Milk... you're recommending a milk not only homogenized, but produced *throughout* under the highest standards of sanitation and purity.



H.P. HOOD & SONS
DAIRY PRODUCTS SINCE 1846

TREASURER'S REPORT
concluded from page 546

JAMES H. DAVENPORT FUND

Established in 1930 by a donation of \$1000 for the purchase of books for the Davenport Collection of non-medical books written by physicians.

89 shares, Providence Gas Company	\$1,068.00
Interest	57.85*
	<hr/>
	\$1,125.85
*Paid to R. I. Medical Society for books	57.85
	<hr/>
Balance	\$1,068.00

* * * * *

CATALOGUING FUND

It was voted by the Council, in 1932, to transfer the amount left from the Clinical Conference Fund to a fund for cataloguing the Library. This, together, with gifts, was deposited to establish the fund in 1933.

Providence National Bank \$20.92
(Transferred to General Fund of Rhode Island Medical Society)

* * * * *

RHODE ISLAND MEDICAL JOURNAL
PARTICIPATION ACCOUNT

Providence Institution for Savings \$670.02
(Transferred to General Fund of Rhode Island Medical Society)

COMMITTEE ON INDUSTRIAL HEALTH

The Committee on Industrial Health was active throughout the year and conducted four important meetings to discuss problems relating to industrial health in Rhode Island.

The Committee has approved of mass x-rays of industrial employees, and it has also noted the progress made by the Medical Society of the County of New York in establishing medical supervision of all industry within its limits. The Committee hopes that similar action may be initiated in Rhode Island, and recommends that the Rhode Island Medical Society study and adopt a program similar to that of New York.

The Committee has conducted a case investigation of reports printed in the daily press relative to the medical phase of the Workmen's Compensation Act in this State. The Committee has found that the reports were not accurate statements of fact as regards the participation of the medical profession in the program. At the same time the

continued on page 550



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In All Anemias

Amenable to Iron Therapy

FERROUS GLUCONATE Breon
offers Iron Stabilized in Ferrous form

Radioactive iron experiments indicate that iron recently administered may be used for hemoglobin synthesis in preference to iron already stored.

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Ferrous Gluconate Stabilized presents

Ferrous Iron Stabilized in a form free of irritating effects, rapidly utilized, effective.

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is useful to promote rapid hemoglobin regeneration in hypochromic anemias.

George A. Breon & Company

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YOU
KNOW
WHAT
THESE
SYMBOLS
STAND
FOR ?**



REXALL FOR RELIABILITY

In medieval times, the dragon was the symbol of the chemist and apothecary. Ancient alchemists were said to use dragon's blood in their potions, and the dragon came to mean certain chemical actions. An apothecary advertised his wares to the world by painting a dragon on a drug pot, and hanging it over his door.

Today it is the familiar Rexall sign which assures you of superior and dependable pharmaceutical service. Displayed over more than 10,000 independent drug stores throughout the country, the Rexall symbol on drugs means pure, potent and uniform drugs, laboratory tested under the rigid Rexall system of controls. It means unexcelled pharmaceutical skill in compounding them.

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LOS ANGELES, CALIFORNIA

PHARMACEUTICAL CHEMISTS FOR MORE THAN 44 YEARS

COMMITTEE ON INDUSTRIAL HEALTH

continued from page 548

Committee is cognizant of the fact that the workmen's compensation plan in Rhode Island may be improved in many of its phases, and it urges that the Society take an active part in making such improvements.

The Committee specifically recommends to the House of Delegates that it authorize the Committee on Industrial Health to draft a suggested fee schedule for workmen's compensation benefits and that such schedule be submitted to the Society for approval before being made public.

The Committee also recommends that the House of Delegates place itself on record as being willing and anxious to check any abuses of the medical phase of the Workmen's Compensation Act in Rhode Island, and that it authorize the Committee on Industrial Health, in particular, to continue to participate with State and private agencies in the improvement of the Act.

The Committee has noted with great interest the expansion of industrial health activities, and it urges the membership of the Committee on Industrial Health be retained in office for longer than a one-year term in order that a successful long-range policy may be developed. In this connection the Committee recommends to the House of Dele-

RHODE ISLAND MEDICAL JOURNAL

gates that there be closer cooperation between the Council of the State Society and the Chairman of the Committee annually relative to the nomination of members of the Society to serve on the Committee on Industrial Health.

COMMITTEE ON INDUSTRIAL HEALTH

Stanley Sprague, M.D., *Chairman*
James P. Deery, M.D.
Arthur E. Martin, M.D.
George Conde, M.D.
Richard F. McCoart, M.D.
Daniel Troppoli, M.D.
Edward Medoff, M.D.
Charles L. Farrell, M.D.
Thomas A. Egan, M.D.

COMMITTEE ON POST GRADUATE EDUCATION

This Committee has not been active because no demand for organized post-graduate teaching has developed in the membership of the Society other than that which is being carried on by the various hospitals.

Speakers and subjects for those district societies which requested them have been furnished by the office of the Executive Secretary from the lists prepared by the Committee. The opportunity to be of

continued on page 552

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NOW SELLING AMERICA'S
FINEST MILK...IT'S

Certified"



Certified Milk

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CERTIFIED MILK
DESERVES YOUR
RECOMMENDATION

Some things you would like your patients to know about Epilepsy

The educational message on Epilepsy, shown below, will appear in full color in LIFE and other national magazines... reaching an audience of more than 22 million people. This is No. 205 in the "See Your Doctor" series, published by Parke-Davis in behalf of the medical profession.

Some things you should know about epilepsy

No. 205 in a series of messages from Parke, Davis & Co.
on the importance of prompt and proper medical care.

EPILEPSY is one of the most widely misunderstood of all diseases.

Many people believe that there's no effective treatment for it, that it's a kind of feeble-mindedness, that it always becomes worse as the patient grows older, and that he has no chance of leading a normal life.

Your doctor, however, will tell you these ideas are false.

The truth is that medical science has accomplished a great deal in its attempt to control epilepsy, and today the outlook for most persons who have the disease is distinctly hopeful.

What is epilepsy?

In broad and simple terms, epilepsy is a disorder in which the patient suffers recurrent nervous seizures. These seizures—usually characterized by muscular convulsions and sometimes by the loss of consciousness—vary greatly in frequency, duration, and intensity.

The fundamental cause of epilepsy is unknown, although a variety of contributing causes have been established.

Contrary to popular belief, heredity as a rule does not play the major role in epilepsy. The chances that an epileptic will have an epileptic child are only about one in forty.

Can epilepsy be controlled?

Epilepsy most often begins in childhood or adolescence. In times gone by, a diagnosis of epilepsy was a dreadfully heavy blow. But today the doctor can usually give the parents—and the child—much encouragement and hope. The following figures explain why this is so:

In approximately one out of six cases, the disease eventually disappears—and disappears completely.

Where the disease does not disappear, nearly 50 per cent of the patients are—with proper medical care—entirely free of seizures. Another 25 per cent or so can be almost entirely free, and can lead a virtually normal life.



The treatment of epilepsy

In most cases, modern drugs are the doctor's chief weapon. Only the doctor knows which drug or drugs should be used, and in what dosage.

Using these medicines, the doctor has been able to give epileptics a new lease on life. Once haunted by the threat of seizures and the danger of gradual mental deterioration, they often spent their days in tragic seclusion. But now most of them can

lead normal lives. They can work, swim, dance, and play golf or other games. Children can go to regular schools and are able to study and play on a par with their schoolmates.

SEE YOUR DOCTOR! If you or your children ever experience a seizure—however mild—see your physician promptly. With epilepsy, as with any other disease, he can be of greatest help when you give him a chance to fight the ailment in its earliest stage.

Makers of medicines prescribed by physicians

PARKE, DAVIS & CO.

Research and Manufacturing
Laboratories • Detroit 22, Mich.

COMMITTEE ON POSTGRADUATE EDUCATION

continued from page 550

service in helping organize the program of the new Veterans Hospital which it was hoped would be given to this Committee has not developed. It is expected that, now that so many physicians have returned from the armed forces and become re-established in practice, a demand for post graduate instruction may develop. It is also anticipated that during the coming year the new Veterans Hospital staff may be organized.

It appears probable, therefore, that in the year ahead, ample opportunities will be presented for this Committee to be of service.

B. Earl Clarke, M.D.
 Frank Cutts, M.D.
 George Alexander, M.D.
 Fred Riley, M.D.
 Henry Moor, M.D.
 Francis King, M.D.
 Elihu S. Wing, M.D.
 Meyer Saklad, M.D.
 Alex M. Burgess, M.D., *Chairman*

COMMITTEE ON THE LIBRARY

The year 1946-1947 has been, in some respects, the busiest in the history of the Library. We have had a total of 1930 visitors; 1749 during the day and 181 during evening hours. This figure is not

RHODE ISLAND MEDICAL JOURNAL

as high as it has been for some of the years before the war but the volume of reference work has been larger than that of any previous year. Many of the subjects have involved hours or even days of painstaking research.

The circulation of books and journals has increased, also. Nine hundred and fourteen journals and 191 books have been charged out and returned during this period; 148 journals and 36 books are out at the present time.

We have added 169 books through purchase, gift and review. Of those purchased, 24 were for the main library, 7 for the Gormly Collection and 6 for the Davenport Collection. The Library is receiving 166 journals through subscription and exchange.

Gifts of books, journals and pamphlets were received from the following: Doctors Abbott, Adams, Beck, Corrigan, Morgan Cutts, DeWolf, Hammond, Kramer, Lagerquist, Mowry, Putnam, Clara and Joseph Smith and Welch, and from the Providence Lying-In Hospital, Providence Public Library, Brown University, Aurex Corporation, Eli Lilly Company, Ethicon Suture Laboratories, Mead Johnson Company, Nutrition Research Laboratories and the National Foundation for Infantile Paralysis, Inc.

Eighty-five volumes of journals were bound
continued on next page

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this year; 6 were repaired. There are 46 volumes at the bindery now.

We have borrowed books from other libraries, through inter-library loan, 8 times and have loaned books 47 times.

The Library shipped 3 large cartons of duplicate journals to the American Book Center in Washington, D. C. This material will be used in the work of restoring the war devastated medical libraries of Europe.

We are arranging, through Doctor Wilson of the Biology Department of Brown University, to loan our partial run of Virchow's Archiv to the University where it will be used to help complete their file. Our volumes, however, will remain the property of the Rhode Island Medical Society and will be available to our members on the same terms as they would be if on our own shelves.

The Library owns 34,402 volumes that have been counted. However, those shelved on the third floor have not been counted for many years and we estimate that our present holdings must be very close to 38,000 volumes. Of these, 23,243 have been catalogued.

Respectfully submitted,

Russell S. Bray, M.D., *Chairman*
Herbert G. Partridge, M.D.
Herbert E. Harris, M.D.
Robert T. Henry, M.D.
Paul Appleton, M.D.
G. Raymond Fox, M.D.
Paul C. Cook, M.D.
Amy E. Russell, M.D.
Clarence E. Bird, M.D.

PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was held Thursday evening, May 22, 1947, at 9:00 p.m. in the Nurses' Auditorium of the Memorial Hospital, Pawtucket.

The meeting was called to order by the President, Earl J. Mara, and the minutes of the previous meeting were accepted as read by the Secretary.

Dr. Shavarsh Harry Markarian and Dr. Robert Jerome DuWors were unanimously elected to membership in the Association after the Secretary reported that their applications had been approved by the Standing Committee.

Dr. Mara asked for suggestions regarding the Woman's Auxiliary for the Pawtucket District and said that there would be more information about this matter at a later date.

Dr. Joseph Doll moved that the by-laws of the Association regarding the present required membership in the State Medical Society be suspended. This motion was put to vote and was defeated only by the negative vote of the chair.

Dr. Charles Farrell gave a brief report from the House of Delegates and also from the Board of Editors of the RHODE ISLAND MEDICAL JOURNAL.

Dr. Mara then introduced the speaker of the evening, Dr. Frank A. Merlino, Clinical Director of the State Division of Tuberculosis Control, who discussed and presented some interesting films on Mass Chest Photofluorography Surveys.

Refreshments were served and the meeting adjourned at 10:00 p.m.

Respectfully submitted,

KIERAN W. HENNESSEY, M.D.
Secretary

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AMA Centennial

There was little doubt in the mind of anyone who attended the annual AMA sessions that the centennial meeting was the biggest, best, and probably the busiest ever held. And since the seashore held little attraction for a New Englander who thinks that the Narragansett shore line tops them all, the convention afforded a busy four days of activity indoors for this observer.

Conference of State Presidents and Other Officers

It was a real sacrifice to relinquish the sunny boardwalk on Sunday afternoon for the confines of the Ritz Carlton to attend the first allied meeting of the convention — the Conference of Presidents and Other Officers of State Medical Societies, an organization Dr. Elihu S. Wing and your observer aided in forming at Detroit some three years back. But the afternoon was well spent, for the talks by the three Cincinnatans — Dr. Schriver, president of the Conference, Dr. Hawley, medical administrator of the VA, and Senator Taft — provided some ideas that provoked much after-discussion by the delegates and other officers.

With the VA program a subject of contention in many parts of the country the remarks of Dr. Hawley drew careful attention. Your observer's notes, hurriedly jotted down, include the following highlights of this talk: That the experience in the VA hospitals where private physicians have served on a part time basis has proved the contention (made by Dr. Schriver in his address) that the veteran will never get the best medical care until the private physician renders it . . . That in the past 12 months more mental discharges have been effected than there have been admissions for mental problems . . . That the VA is required to provide out-patient service and there appear to be two ways to do it, (1) by providing clinics, or (2) by abolishing all existing VA clinics and having the work done by general practitioners . . .

But it is impossible to provide clinics, as that would necessitate one in almost every county; and while the abolishing of the clinics in favor of care by private physicians has merit, its disadvantages include the failure of the general practitioner to make the pension claim examination as well as the clinic (due to reporting of findings, etc., and *not* due to zeal or ability of the physician), and the problem of providing prosthetic appliances . . . Then, too, claims are settled by a lay board and hence trained VA medical personnel are necessary to present clearly the case . . .

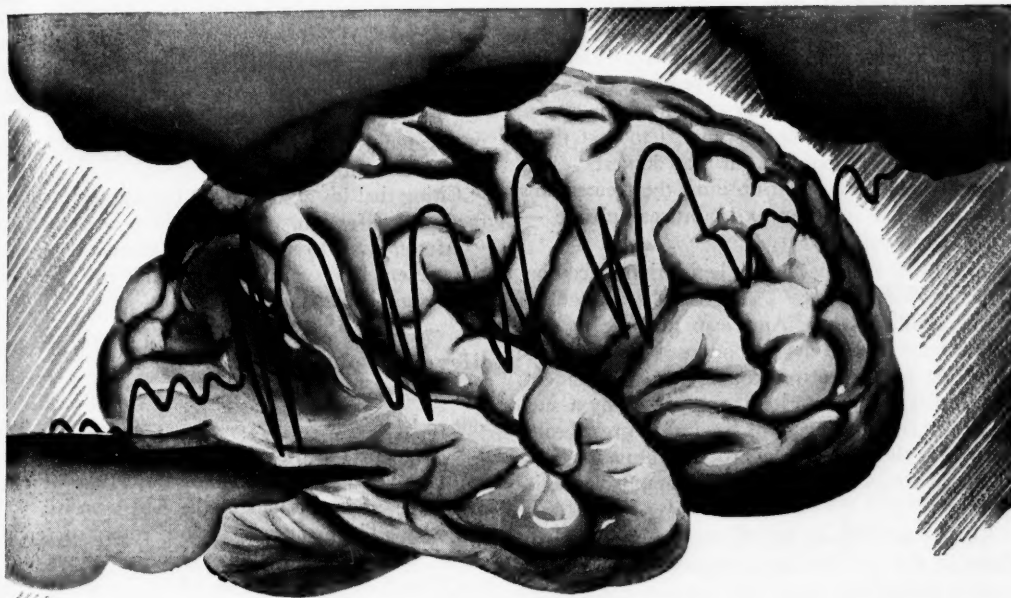
The problem, according to Dr. Hawley, might be adjusted by (1) limiting the number of clinics, and (2) using the general practitioner as much as possible. In the main, he pointed out, the present situation is subject to adjustments arising from (1) misunderstandings, (2) both active and passive resistance by the 'old guard' in the VA who do not favor the new program, and (3) sheer stupidity.

Considering the fee question, Dr. Hawley pointed out that he felt that the fee schedule with societies should be negotiated on the basis of (1) adequate fee for the physician to give the veteran the complete security of a private patient, and (2) protection against overcharges . . . The great majority of the profession has been most fair to the veteran and the VA, but a small percentage of doctors can give a "bad name" to the profession . . . Agreements in 38 states now result in the payment of approximately 32 million dollars a year to private practitioners, an average of \$213 per year per physician on a 48 state basis.

Taft Discusses National Health Legislation

Speaking forcefully, and with an apparent sincerity, Senator Robert Taft brought to the Conference a better understanding of the health issue at the national legislative level. After reviewing the development of such acts as the Hill-Burton hospital construction measure; the Scientific Foundation act to provide

continued on page 556



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THROUGH THE MICROSCOPE

continued from page 554

for a study relative to the distribution of funds for research, including cancer and heart disease; and the Pollution Abatement measure (in which Rhode Island has a vital stake) estimated to cost three billion dollars, he pointed out that domestic plans must necessarily be held up until the tremendous appropriations for war expenditures subside — possibly in another year.

Discussing national health legislation placed before Congress, Senator Taft drew sharp attention to the conflict in the American philosophy with reliance on a free system opposed by complete operation of the entire economy by government. Citing that the free system, augmented by a supplemental charitable system, has built a great health record for this country, he proceeded to a criticism of the Murray-Wagner Dingell compulsory legislation.

Similar to previous legislation by the same proponents, the new act, according to Senator Taft, implies payment of a 4% tax, but does not levy the tax or tell how it will be paid. This method of writing the measure was done in order to keep it out of the Finance Committee which would necessarily be primarily concerned with costs of operation which would ultimately effect the entire economic pattern of the country. Citing that 4% of a \$3,600 income is twice as much as the Michigan and California medical service plans now charge for their voluntary insurance programs, Senator Taft drew attention again to the fact that the M-W-D act is NOT insurance, but a tax plan.

Stating that some states are faced with great difficulty now in raising funds on the local tax level for essential services such as schools, roads, etc., and that the federal government is raising 40 billion dollars, and the States another 10 billion, Senator Taft maintained that further increases at the state level will result in the loss of productive businesses. (And your observer was mindful of the recent Assembly and public discussion in Rhode Island on the state budget which has resulted in a new sales tax to meet what are now current state government expenses).

Health, according to the Senator, has generally been at the tag end of the budget, with the result that the poorer states are not coming anywhere near meeting public aid needs. Hence, he advanced strong arguments for his Taft act, now before Congress, which would give assistance to the 20% of the people who need it, and not force it on 95% as proposed by the Murray-Wagner-Dingell-McGrath measure.

Under his act, Senator Taft proposes a fund of 200 million dollars to be given the States to aid

RHODE ISLAND MEDICAL JOURNAL

any state to set up a plan to provide medical care for all who cannot purchase it. The plan involves a means test; but, he pointed out, every hospital and every physician now has to apply some means test in rendering services. Also, public housing is predicated on a means test. Hence this objection has little merit in fact.

Citing that his act (S. 545) does not control the medical profession, he posed the question to the Conference as to whether we want to improve the present free system, or abolish it for a government-controlled system.

**House of Delegates
Meeting**

On the Monday the House of Delegates assembled for what turned out to be a very busy week of activity. The early sessions saw the introduction of delegates representing the various nations of the world who extended special greetings to the AMA on its 100th birthday. Then came the serious round of reports of committees, resolutions, and discussions.

Of particular interest to Rhode Island was the supplementary report of the Council on Medical Service which included a preliminary statement of a study of cash sickness compensation programs and promised a detailed study later. (In July, 1946, the R. I. House of Delegates submitted a resolution requesting that the proper council or agency of the AMA make a study of the medical phases of cash sickness compensation plans and report by the first of this year.) Another item of interest in the report from this Council was the request that it be authorized to meet with the Veterans Administration and endeavor to effect a more satisfactory agreement relative to care of veterans through cooperative efforts of state medical societies. These, and the many other reports and resolutions (some interesting ones relative to the general practice of medicine, hospital specialty boards, etc.) have been or will be published in the Journal of the AMA, and warrant reading by all members.

**Surgical Study Committee
Holds Meetings**

During the convention week members of the surgical study committee of the Rhode Island Medical Society, headed by chairman Dr. Rocco Abbate, met with representatives of other states that are interested in the development of the voluntary surgical plan through private insurance companies. A meeting was also held with representatives of the Council on Medical Service of the AMA which recognizes the Rhode Island approach as one of the best advanced to date, and as superior in many respects to the Wisconsin Plan, the forerunner in this method of extending prepaid surgical and medical care under state medical society sponsorship. It is of in-

continued on page 558

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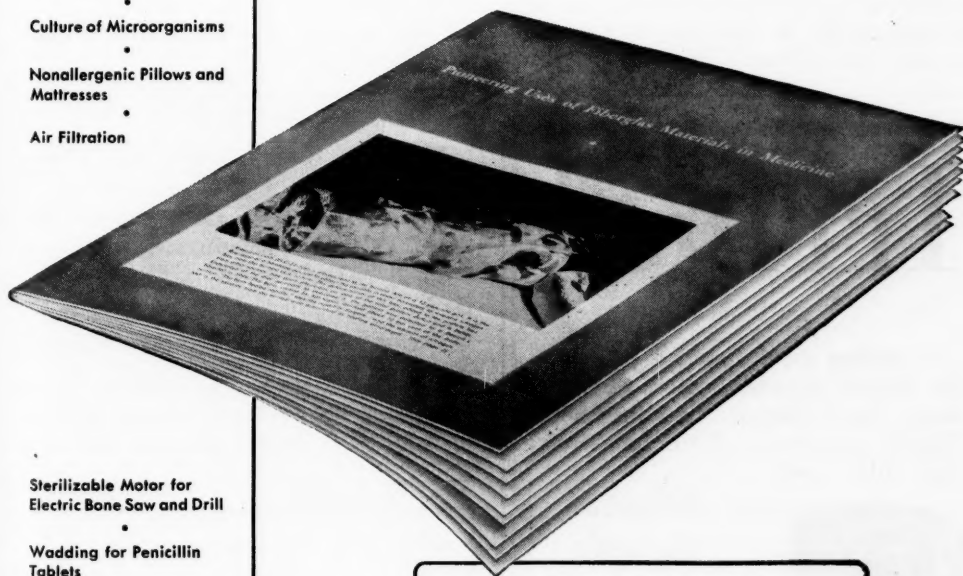
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THROUGH THE MICROSCOPE

continued from page 556

terest to note that the Arkansas State Medical Society has given the John Marshall Insurance Company of Chicago, a private stock company, its exclusive endorsement to merchandise a low cost medical-surgical-hospital program to the two million residents of that state; Illinois is studying such a program, as is Tennessee and Minnesota, to name a few of the leaders in the field. Of greatest interest to all was the fact that Rhode Island has been able to bring some of the major insurance companies of the country into its program.

At the Exhibit Hall

It was not until Wednesday morning that your observer took time to visit the convention hall to see the exhibits. And see is the right word, for it would require the time of several days actually to travel the entire hall, stopping and studying the hundreds of technical and scientific displays. Naturally we made a stop at the scientific exhibit presented by Drs. Meyer and Elihu Saklad, and Priscilla Sellman, only to find such a group of interested physicians listening to Dr. Sellman explain the technique presented that we never did get to the front row to make our presence known.

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We were to meet Dr. Batchelder "under the clock", but that spot proved one of the most popular with free "cokes" being dispensed at one booth, and cigarette cases at an adjoining one. The result: Dr. Batchelder and your observer never did meet to check some of the exhibits that we might seek for showing at Providence next year for the Providence Medical Association Centennial. But your observer did learn a few facts previously not known to him, that (1) the 1847 registration book of the AMA for its first meeting carried the names of two Rhode Island delegates, Dr. Theophilus C. Dunn (whose name we never recalled) and Dr. Usher Parson of whom we have read much relative to his exploits as the only surgeon with Oliver Hazard Perry's fleet at the battle on Lake Erie; and (2) that Rhode Island was the tenth state medical group to officially organize (New Jersey was first, in 1766).

CENTENNIAL MEETING OF THE AMA

concluded from page 522

President Elect: Roscoe L. Sensenich, M.D., South Bend, Indiana.

Vice President: Thomas A. McGoldrick, M.D., Brooklyn, N. Y.

Secretary and General Manager: George F. Lull, M.D., Chicago, Illinois.

Treasurer: Josiah J. Moore, M.D., Chicago, Illinois.

Speaker of the House of Delegates: Roy W. Fouts, M.D., Omaha, Nebraska.

Vice Speaker of the House of Delegates: Francis F. Borzell, Philadelphia, Pa.

The next meeting will be held in Chicago.

Respectfully submitted,

GUY W. WELLS, M.D.

Delegate from Rhode Island

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JOURNAL

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BOOK REVIEWS

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9th Edition 1947 DeLee-Greenhill. W. B. Saunders Company.

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CHARLES POTTER, M.D.

FUNDAMENTALS OF CLINICAL NEUROLOGY.

By: H. Houston Merritt, Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University; Fred A. Mettler, Associate Professor Anatomy, Columbia University; Tracy Jackson Putnam, Professor of Neurology; Neurological Surgery, Columbia University. Pg. 261. The Blakiston Co., Philadelphia, Pennsylvania.

This book has worth. The fundamentals of clinical neurology are so well depicted. The combining of anatomy and pathology, to make the clinical picture have meaning, has been skillfully brought about. The authors are to be congratulated for blending so adeptly their special interests into a unified whole. For the general practitioner, the beginner in neurology, and the expert in neurology, this happy blending will be most useful and satisfying.

This book is successful in other ways. The exposition of the ideas is done clearly and in a most readable fashion. Sentences are short. Words are chosen for the primary purpose of getting over an idea. There is joy in merely reading the book. Exemplary of this point are the accounts of "The Babinski Phenomenon" and "Muscular Disorders Due to Myoneural Junction Dysfunction".

The extent of the index and the care with which it has been done adds materially to the value of this book.

Most physicians will respond very favorably to the type used and the arrangement on the page. Certain diagrammatic anatomical illustrations could be improved perhaps by using more than color for contrast. It is believed this book will be an essential in a collection of neurological text books for years to come.

HAROLD W. WILLIAMS, M.D.

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